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It is a rare State in the Union that has no children of migrant farm families, but Florida's quota is particularly complex. Though the problems are interstate in character, Florida is showing that it can, on its own, make some headway with them, as is shown in Dorothea Andrews' article, MOPPETS WHO MIGRATE. Miss Andrews rounded off 6 years of reporting on health and welfare matters for the *Washington Post* before serving, for 3 years, as Press Officer for the Children's Bureau. She is now a free-lance writer.

How teamwork can speed up progress in dealing with a difficult problem in child health is the theme of Dr. Bechtol's article on prostheses for amputees. A member of the Upper and Lower Extremity Technical Committees of the Advisory Committee on Artificial Limbs, Dr. Bechtol is also Western Area Consultant to the Veterans Administration for orthopedic and prosthetic clinics, and Director of the physicians' program for the upper extremities.

One of the very few medical social workers in the Nation engaged full time in child health clinic work, Theresa Harder has behind her 14 years of professional service, divided almost equally between hospital and public health medical social work. In 1947, when she joined the District of Columbia Department of Health, she worked first in the Crippled Children's unit. More recently she has worked exclusively in child health clinics.

Our two reviewers of the new *Standards* for juvenile courts each has had close working relations with the other's profession. Professor Bradway, in addition to teaching law and directing the Legal Aid Clinic at Duke University, is a visiting professor at the University of North Carolina School of Social Work. He has pioneered in developing for law students clinical preparation for practice such as medical students get.

Before Mr. Anderson took his present position in 1953, he served for 6 years as Director of the Family Court for Newcastle County in Delaware where he was chief of probation services. Mr. Anderson was associated with the Cambridge-Somerville Youth Study (1938–41) made in 2 industrial cities in Massachusetts to test the effectiveness of special counseling and aid to "predelinquents."

Accident prevention has been an absorbing interest of Dr. Press for over 10 years. A member of the Accident Prevention Committee of the American Academy of Pediatrics, he also is Vice Chairman of the Health and Medical Division of the Home Safety Conference of the National Safety Council, and Chairman of the Chicago program described in his article.

All three physicians who author the article on San Francisco's Community-School Health Education Project have behind them wide experience in public health work. Dr. Singer-Brooks, who was on loan from the State Department of Public Health for the duration of the project, had been active in research before entering public health work in Sacramento, in 1950. Dr. Van der Slice's experience in school health programs covered a number of cities in Michigan before he joined the California State Department of Health in 1948. He went from the State to his Oakland position in 1950. Dr. Barrett was appointed Director of the San Francisco Bureau of Child Hygiene in 1931.

frontispiece

CHILD HEALTH AND WELFARE AGENCIES that struggle with the problem of how, photographically, to tell a story but do no injury to the recipients of service will find in this exquisite photograph of a child grasping a finger of his father's hand an illustration of photographic resourcefulness. This photograph, by Arthur C. Allen, was generously furnished by the Illinois Children's Home and Aid Society.

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READERS' EXCHANGE

GALLAGHER: "Both sitting on Mark Hopkins' log"

The comments of my good friend, President Gallagher ("The False Dichotomy of Professional *versus* General Education," CHILDREN, Vol. I, No. 2, pp. 46–49), have left me in this dreamlike daze that so often follows a rousing *non sequitur*. After a mental "double take," I am forced to conclude that we are speaking a different language.

Far from being the spokesman for "the case for the substantial elimination of liberal and general education in favor of professional competence," I have maintained during all of my professional life that studies in the social sciences and the humanities are an essential part of "professional competence" as opposed to mere technical proficiency.

A sociologist myself, my wide advocacy of this ideal brought my appointment as the first Dean of Humanities at the Massachusetts Institute of Technology in 1937. Under my administration at The Cooper Union, the curricula in art and engineering introduced liberal arts studies in an amount up to a fifth of the class hours required for graduation. And I have just been named chairman of an Advisory Committee for a comprehensive investigation of engineering colleges launched by the American Society for Engineering Education under a grant from the Carnegie Corporation, which has as its purpose the improvement of courses and teaching methods of socio-humanistic studies.

After long years of such activities, it comes as a shock to be accused of trying to resolve the problem of professional versus liberal education "by eliminating one or the other, or by separating one from the other." President Gallagher's "unstated conclusion" has been reached by a record-breaking broad jump that is the more spectacular since it was made backwards and blindfolded.

It is true that I argued that higher education, under present practices, was pricing itself out of the market and I suggested that one solution might be to give more education in less time. Here are . . . pertinent paragraphs from my report that led to President Gallagher's amazing paper:

"The colleges must reduce their cost by giving more education in less time, and by instilling in every student a passionate desire for filling in the gaps in his education through post-college study . . .

"Rising costs, combined with a little realized and less understood change in the social order, must of necessity bring about an acceptance of a less expensive and shorter educational base.

"If our educational structure were more flexible, I would urge . . . that the junior high school and the first 2 years of high school be combined into a "middle school" and the last 2 years of the present high school program be tightened up scholastically to the academic calibre of the European gymnasium or lycee.

"These new senior high schools would have two objectives. One type would . . . have a pronounced vocational content in order to equip its graduates to enter business, trades, and the arts. The other type would serve probably about two million youths who through self-imposed screening have demonstrated to themselves their intellectual promise for education and training for the professions. Since such a fundamental reorganization seems remote, the next most intelligent development would be to ascribe more acceptability to the junior college and to establish the desirability of the 2-year degree of 'associate' in arts or science for all except those entering the most exacting professions."

When President Gallagher proposes to meet me on my own ground, he will find that he need not travel far, since we are both sitting on Mark Hopkins' log . . .

If President Gallagher is setting up a pageant for his crusade to establish a world series tilt at the windmill of educational antinomianism, I must refuse the role of the archvillain, Sir Mordred. Type casting, I feel, should put me in the shining armor of Sir Galahad.

Edwin S. Burdell, President,
The Cooper Union for the Advancement of Science and Art

I am very pleased that President Burdell—whom I count not only as a good friend but also as one of the ablest of educational administrators—has been given an opportunity to recast himself in an appropriate role as this material goes to press.

I accept completely his correction of his intended meaning, and regret that either his ellipses of phrase or my own intellectual obtusity prevented me from seeing through his language to his real intentions. I am content to let Burdell disclaim the characterization as a straw man, for I was not aiming my darts at him as an individual. I take it that he and I stand together in common opposition to the position which I had attributed to him—and I thank him for his good natured willingness to let the accusation stand, provided it applies to a position which he disavows.

Buell G. Gallagher, President
The City College, New York.

MAURICE PATE "Inspiring saga"

The story of UNICEF's tremendous work in combating disease, hunger and ignorance among the world's needy children without regard to color, creed or nationality, is one of the most inspiring sagas of modern times. The article by Maurice Pate, Executive Director of the United Nations Children's Fund (UNICEF) which appears in the March–April issue of CHILDREN (pp. 70–76) is a message which every American should read and be proud of . . . UNICEF has proved that the United Nations is a truly effective means of building a better world. Mr. Pate shows that this world organization means not only formal debate but a forceful and direct attack upon the practical problems oppressing mankind.

More than 70,000,000 children have received assistance from UNICEF, but

> **Men are never so likely to settle a question rightly as when they discuss it freely.**
> T. B. Macaulay: *Southey's Colloquies* 1830

there are still more than 500,000,000 children living in areas where health and welfare services are inadequate, disease and hunger rampant. The United States shares with the world a responsibility to continue to provide UNICEF's services—the best support for the future peace and happiness of the world's people.

Helenka (Mrs. Guido) Pantaleoni
Chairman, U. S. Committee
for UNICEF

DYBWAD: "All kinds of parents"

As a person with experience with parents' groups, I have read with mixed feelings Gunnar Dybwad's article ("Leadership in Parent Education," CHILDREN, Vol. I, No. 1, pp. 10–14). While I admired his carefully documented approach, I felt some disappointment in his failure to deal explicitly with parents as persons.

There are all kinds of parents, and all varieties of parents' groups. In my experience, it is imperative to recognize the tremendous variations among parents, in background, in readiness, in definition of the situation, in degree of involvement, and in the motivation that brings them to parents' groups.

Consider, for instance, the difference to be found between a group of mothers of very young children concerned with toilet training, food habits, and the other elementals of early parent-child interaction, and the interests of a group of parents of adolescents facing the threats and strains of parent-adolescent conflict.

Or, take as other simple examples of group variation, the small group of second generation city mothers who meet in a neighborhood house, the sophisticated urbane men and women who attend parents' sessions in a downtown office building, and the farm women who come for a series of meetings on child development under the auspices of the extension department or the county health program.

The unique orientation of each group, and ultimately each person, must be recognized and used insightfully by the leader if a dynamic educational process is to be established. Just because the groups are made up of parents is not definitive enough to be helpful to the sensitive educator.

One of our problems lies in the very approach we take to parents. As long as we see them as the way in which we can influence their children, we play a kind of mental leap-frog with them. We touch them, true, but only so we may reach their children. It is only when we become interested in parents as persons that we can hope to meet their needs effectively.

Evelyn Millis Duvall, Ph. D.
Family Life Consultant and Author
Chicago, Ill.

I have no disagreement with Mrs. Duvall. As I stated, my comments on the "nature of parent groups" were "necessarily brief." Of course one deals with parents as persons, but whether we worked with groups from Harlem, Brooklyn, or more privileged Connecticut, with non-English speaking immigrants or sophisticated suburbanites, we found the same basic needs for skilled leadership.

Gunnar Dybwad, J. D.
Director
Child Study Association of America

A NEW ATTACK ON MIGRANT PROBLEMS

A PILOT PROJECT to bring nomadic children and stay-at-home services for children closer together will have been set in motion by the time this issue of CHILDREN reaches our readers.

Leaders in health, education, and welfare in 10 States on the eastern seaboard, meeting in Washington in May, are expected to work out some specific plans of action at a conference called by the Public Health Service, the Office of Education, and the Children's Bureau.

The concern of this group will be the children of migrant families who move out of Florida in the late winter, follow the fruit and vegetable crops up the east coast States to New York, then return for the winter crops in Florida.

These children were chosen for special study not only because they are part of a fairly small, homogeneous group, following a somewhat regular migratory route, but also because there is lively interest and activity in doing a better job for these children in a number of the States they touch.

States asked to send representatives were New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, North Carolina, South Carolina, Georgia, and Florida.

Some of the practical interstate tie-ups that the Washington conference will explore, in an effort to break down the isolation of these children and to woo communities and children into closer kinship, are these:

How can these States interweave their services so that each builds on the work the others do for these children?

Can Florida, for instance, identify those expected to migrate; get them ready, through physical examination and immunizations; provide them with health records that can be used en route; arrange for the States ahead to locate those needing health follow-ups and treatment?

Between them, can these States provide better articulation of school experiences, from school to school, from State to State? Can better record forms be developed which the youngsters carry with them to guide teachers in their programs?

Can a better job be done to identify services that migrant families themselves want, and to increase community acceptance of them?

A Joint Committee on Migrants, with membership from the three inviting Federal agencies, in the United States Department of Health, Education, and Welfare, has been formed to backstop the efforts of the States in this pilot project.

CHILDREN will report on developments in later issues.

Florida, a "sunshine State," takes a look at some of the darker sides of life within its borders, and works to do something for its . . .

MOPPETS WHO MIGRATE

DOROTHEA ANDREWS

THE TOWN DUMP is piled high with beer cans, and the whole unsightly mess is only partly obscured by palmettos. Out past the dump, in a little clearing, there is a tent, covered with burlap and canvas.

In it live a migrant agricultural worker, his wife and their four children.

The screams of a child could be heard coming from the tent as we drove up in the clearing. A boy of about eight emerged, holding a leather belt in his hand.

"What are you doing, sonny?" we asked.

"Trying to make these hard-headed kids behave," he said. Out came the "hard-headed kids"—all three of them—with their dirty faces turned questioningly in our direction. None seemed more than 5 years old.

"Why aren't you in school?" we asked the eldest.

"I have to stay home and mind the babies," the little boy said.

Why does a community let a thing like this happen? The community—in this case Immokalee, Florida—"let a thing like this happen" because during the past 5 years, it has been inundated by thousands of people who have enlarged its normal 800 population past the bursting point. They came to Immokalee seeking work at harvest time, which is about 6 months each year. The town is simply not equipped to cope with them.

What are the parents of these children thinking of? They are thinking about earning money. Earning enough money is the obsession of migrant workers. To get it they will put up with little or no sanitation, little or no housing, a diet of cold rice, cold beans, cold cornbread. Their children, also, must put up with a bad diet, bad housing, with at best uncertain schooling.

The little boy in Immokalee is not a special case. Hundreds of boys and girls of school age are staying home to "mind the babies" while their parents work in the rich-loamed fields of Florida.

But hundreds of others are going to school. Some are finishing high school, and some are turning to other vocations and away from the migratory pattern which their parents follow.

Florida has the problem of migratory agricultural workers to a greater degree than any other single State on the east coast. It is from this State that workers fan out into the migratory stream on the east coast and into the midwest. Because Florida has so many diversified crops, and such a long harvesting period, migrant workers can hope to find work in the State for 6 to 10 months of the year.

This report, largely through the examples of Immokalee where it has been possible to make the least advances against the problem, and of Palm Beach County where much has been done, will attempt to describe some of the ways in which the problem of the migratory worker manifests itself in Florida, and some of the ways in which State and voluntary agencies are trying to meet it.

The Florida migrant worker himself is not easy

"Provision of adequate health services for migratory agricultural laborers and their families has been a serious problem for the Florida State Board of Health since vegetable growing first became an important industry more than 20 years ago. Much has already been accomplished in the older and better established growing areas, but much remains to be done especially in newer areas. Other Florida State agencies, such as the Department of Education, are keenly aware of this problem and are interested in improving and extending services within their respective fields. The current interest of both State and Federal agencies is certainly encouraging and will undoubtedly result in further progress if their efforts can be effectively coordinated."

WILSON T. SOWDER, M. D.
Health Officer
Florida State Board of Health

to describe. He may be white, Negro, Texas-Mexican, Puerto Rican, Bahaman, Jamaican.

How many migrants are there? Nobody knows. The estimate is that between 60,000 and 70,000 workers with wives and children migrate to Florida each year for agricultural work. But how many of the wives and children of these workers also work is not known. The estimate is based on those who register for work with the State employment office. It does not take into account the "free wheelers," who drop in from nowhere, pick up work as they go, who may live in the community, in a labor camp, or "squat" on unoccupied land. How many free wheelers there are is anybody's guess.

Migrant Patterns Differ

Where does the migrant worker go when he leaves Florida?

If he is white, he probably came from one of the southern or southeastern States. An estimated 50,000 Florida migrants, both white and Negro, are from the eastern seaboard and southeastern States. The white migrant may come to Florida to supplement his meager earnings in agriculture or textiles in his home State. In the off-season, he leaves Florida and goes back to his home base. If he is a true, year-round migrant, he usually follows the midwest migratory stream, pushing up by way of Arkansas and Indiana into Michigan for the fruit picking season.

If he is Negro, he is more likely to be a year-round migrant, and will join the east coast migratory stream, working his way up through the Carolinas, and into the middle Atlantic States until he gets to New York in the late summer and early fall, then start the backward trek to Florida again.

If he is one of an estimated 6,000 Puerto Ricans, he will probably follow the east coast stream.

If he is a Texas-Mexican—estimate, 2,000—he may stay in Florida year-round, picking up supplemental employment where he can.

If he is one of the estimated 10,000 "offshore" workers from the Bahamas and British West Indies, he is hired on a contract basis, and returns to his home base during off-season.

What are the migrant's problems? To himself, the major one seems to be making enough money to live on. He lives from hand to mouth because of the uncertainty of future employment.

To the community, the migrant is a housing problem. To the health department, he is a health and sanitation problem. To the school authorities, he is a school problem. To the welfare department, because of Florida laws regulating eligibility for public assistance, he is an occasional problem on an emergency basis.

To the growers who employ him, and to the Nation at large, the migrant is an economic necessity to harvest crops of cotton, citrus, cucumbers, potatoes, cabbages, strawberries, corn, celery, tomatoes, sugar cane, beans and other vegetables.

Grower Has Annual Gamble

While the migrant worker gambles on future employment, the grower, for whom he works, is engaged in a bigger gamble of his own. Every time he plants a crop, he stands to "lose his shirt."

If he is to bring in a money crop, he must have several things in his favor: the weather must be good, with no serious freezes; there must be just the right amount of water for his crops, with no heavy rains close to harvest; migrant labor must be on hand in plentiful supply at harvest. If migrant labor is in short supply, the grower must pay top labor prices, although he cannot increase the price of his crop in proportion. If the grower's crop is a little late in coming in, he knows the migrant worker may be on hand one day and gone the next, to harvest another crop where he will get "first pickings." Every year, one or more of these factors doesn't work to the advantage of some growers.

Growers in most parts of Florida have a better chance to win on their gamble than do growers in Collier County, a less fertile and well-developed

land area. Collier County, of which Immokalee is a part, is largely owned by a few interests that are not willing to sell their land, but will enter into annual lease agreements.

Collier County Has Special Problems

The Collier County leasing grower knows that any improvements he makes on the land will figure in next year's price. Yet a number of growers decided a few years ago that they could "make it" even with the added gamble which cultivation of the land presented.

As a result, Immokalee has seen a 5-year influx of migrants, equally divided between whites, Negroes, Puerto Ricans and Texas-Mexicans, who heard by the grapevine that the town had a labor shortage. The migrants are packed into malodorous, tiny cubicles with indescribably meager living arrangements. Two complete blocks of shacks are served by a single outdoor spigot. Everything from an abandoned bus to a piano box serves as "home."

As a result, the facilities of the unincorporated town of Immokalee have been taxed beyond limit. The crisis brought about establishment of a part-time health department but residents must travel 35 miles to the nearest hospital. The county commissioners have set aside $600 from their welfare budget to help in frequently arising emergencies.

Because Immokalee has more migrant workers during the harvesting season than the need justifies, about 90 percent of the growers bid for the help they need on a daily basis. They may ask for bean pickers at a rate varying from 50¢ to $1.15 per hamper, depending on the labor supply. The grower's responsibility for his pickers ends when he brings them back from the fields at night.

In some areas, growers have tried to provide rent-free housing for their workers, with the stipulation that they seek no other jobs as long as the growers need them for their own crops.

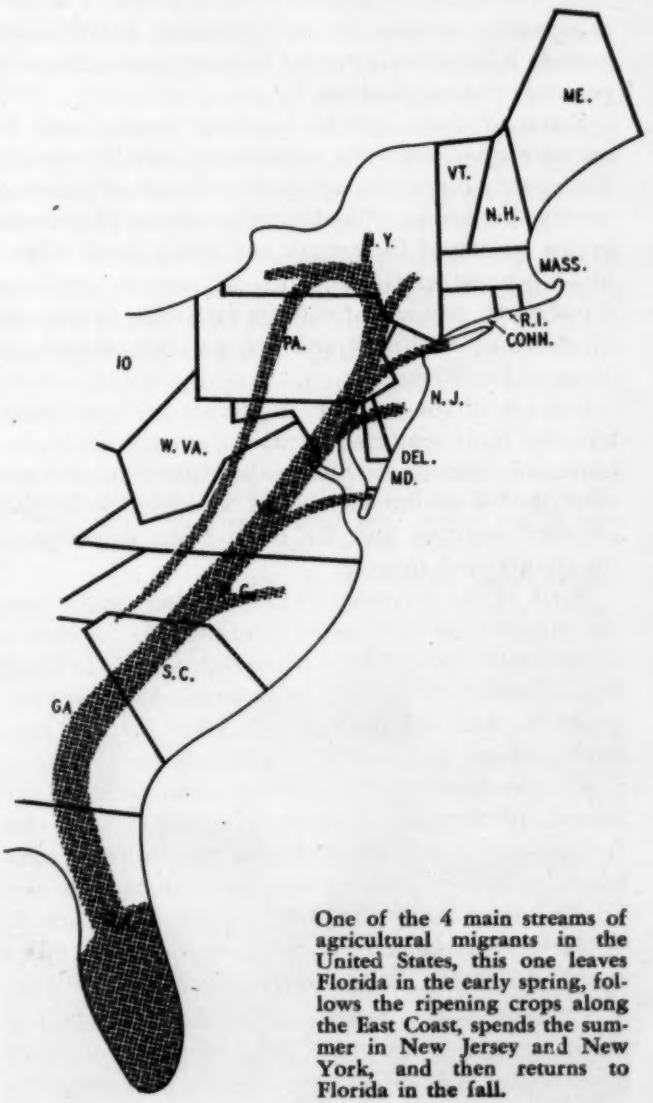
Few Immokalee growers provide such housing. Last year they had a bad year, and it is not realistic to suppose they will invest in housing on leased land to any great extent unless and until they show a substantial profit for their crops.

Collier County is further disadvantaged because it is not the site of one of the migrant labor camps built under Federal sponsorship in the early '40s to house migrant agricultural workers.

In the Everglades area in Palm Beach County, for instance, five labor camps for migrant agricultural workers were built by the Farm Security Administration and operated during World War II by the War Food Administration. They represent the best housing available to migrants. When the Federal Government moved out of the housing picture after World War II, local housing authorities took over the camps and are continuing their operation.

Two of the Palm Beach County camps are located in Belle Glade. One, for white migrants, houses 1,000 people. The other, for Negroes, houses 2,000. Rents range from $3 to $10 per week, depending on size and construction of the units.

The camps are well-kept, with turfed grounds, and community laundry and toilet facilities. Each of these 2 camps has a school on the grounds, and a health clinic staffed by a public health nurse from



One of the 4 main streams of agricultural migrants in the United States, this one leaves Florida in the early spring, follows the ripening crops along the East Coast, spends the summer in New Jersey and New York, and then returns to Florida in the fall.

the Palm Beach County Health Department.

Camp managers estimate that of the whites living in the Belle Glade camp, less than 2 percent are migrants in the old sense. Many former residents of the camp have moved into permanent housing in the town of Belle Glade. In the Negro camp, an estimated 30 to 35 percent are year-round residents.

In both camps, there is a heavy demand for standby rental agreements, by which tenants leave the project for part of the year and pay a reduced rental to hold their dwellings.

The Belle Glade Housing Authority is considering expansion of its housing operations, not by enlarging the camp, but by building permanent low-cost housing within the Belle Glade area.

For existing housing is by no means adequate. Belle Glade has grown in permanent population from about 4,500 in 1940 to 7,000 in 1950. The area is annually swollen by an additional 12,000 (estimated) migrants during the harvest season, about 65 percent of them Negroes.

Some of them live in migrant camps, some in growers' quarters, some in privately owned housing. The county health department in March of this year surveyed quarters offered to migrants by 24 growers in one section of the county and rated them "Poor" in 54 percent of the housing, 50 percent of water supplies, 92 percent of sewage facilities, 88 percent of screening facilities, and 100 percent of garbage disposal facilities.

Because of the number of private growers' quarters and their scattered locations, county health department officials estimate the full-time services of at least 3 sanitarians would be needed to inspect growers' quarters and the large migrant camps in the county each month.

Much of the privately owned housing available to the migrants is even more substandard. A stone's throw from the well-kept white camp at Belle Glade is a collection of shacks, fully occupied, where migrant workers are paying high rents for less than basic housing and sanitary facilities.

Another factor in the housing situation is the apparent preference of many Negro migrants for living—even in substandard housing—in Negro communities rather than in migrant camps. In one Glade town, many Negroes clamor for space in "Streamlined Quarters," even though it offers crowded housing and primitive sanitary facilities.

A county health department sanitarian tells how he tried to get a "Quarters" property owner to build flush toilets for community use. Later, when the whole area was threatened by fire, the sanitarian wryly recalls standing, with garden hose in hand, determined to save the newly built toilets from destruction. He was successful, although some of the housing did burn.

In both camps and growers' quarters, where public toilets have been supplied, there has been both abuse and misuse, as there often is in filling-station facilities used by much more affluent migrants. However, many of the migrants do not know how to use toilets, and resort instead to open areas in the vicinity.

The Palm Beach County Health Department believes that while it has more problems with its resident population than with the migrants, the number of migrants with problems is proportionately greater than that of the resident population of comparable economic status. The migrants' problems therefore are given priority.

Migrants' Needs Illustrated

Here are two case histories which illustrate some of the needs of migrant workers who come into the county, as written by a public health nurse:

"In 1950 I first became acquainted with the H. family. They were a small family with 2 children, who arrived from Alabama where they picked cotton. The children were then 3 and 4 years old. Mrs. H. needed dental care badly. The 3-year-old child needed a hernia repair and the doctor said it was dangerous to delay.

"But before anything could be done they were off to Michigan to pick apples. Back again and Mrs. H. is pregnant, 7 months, no prenatal care. She apparently had been pregnant when she left here. Crops are poor, so she is delivered by a colored midwife whom they forgot to pay. After 5 days I'm summoned to the house and find the mother has a temperature of 105. No food, no work for the husband. There was a freeze that season.

"Finally the Home Missions Council came to their aid, and Mrs. H. was hospitalized. She recovered after a long illness, but before dental care could be obtained for the mother, or surgery for the girl, now 4, they're off to California, new baby and all.

"The fall of 1951 and here is the H. family back again. By now, the father has had an automobile accident, and has an injured back, both younger children need hernia repairs badly, and Mrs. H. still needs a set of teeth, but Florida residence was never established, so they aren't eligible for any help. The middle girl finally has a strangulated hernia, and a

local civic organization helps pay for the operation. The baby had whooping cough because mother could never quite get to the clinic on time for immunization. The H. family is gone again, but they will still have their problems (plus new ones) when they return in the fall.

"Then there is the C. family, with 8 children ranging from 1 to 12 years and no father, who arrived from Arkansas. Jimmy, aged 10, has rheumatic fever. The mother needs V. D. treatment. All the children need dental care. Two need tonsillectomies, and the baby has rickets, since the diet consists mainly of cornbread. This family has so many problems, and there is so much to be done for them, yet they soon are off to New York to pick apples."

County Reports Health Progress

The Palm Beach County Health Department, since its organization in 1948, has moved on several fronts to better the health of the migrants.

It set up a low-cost maternity program in a deliberate move to compete with unqualified midwives in the county and reduce infant mortality. Many migrant women have taken advantage of the plan under which they get 2 days of hospital care for rates varying from $25 to $30, with a doctor charging a like amount for delivery. The number of midwives in the county has been reduced and those now in practice have undergone a training and internship program.

On the staff of the county health department is a sanitary engineer to improve the housing and sanitation of the migrant workers.

The county's four health centers all are located in migratory labor camps. Although the migrants have the benefit of public health nurses through their clinics and home visits, estimates are that, to meet the migrant need alone in the county, four more public health nurses should be added to the staff.

The job of seeing the migrants where they are is a problem in itself. A public health nurse in the county found, on one grower's property, 24 infants on a double bed, being cared for by an elderly woman while the children's mothers worked. With the cooperation of the grower, the nurse developed some basic standards for a day nursery at the camp. The grower pays the salary of a worker who operates the nursery under the supervision of the nurse.

The county school system also has moved in on the migrant problem. The schools in the migrant camps are an integral part of the school system. One of these is a school for exceptional children. In this county, as elsewhere, there is overcrowding in the school system, but the migrant children appear to be neither more nor less disadvantaged by this situation than are the resident children.

The welfare department plays a limited role in the life of the migrant. The department has a worker in the Everglades and two in West Palm Beach, who operate only in the specific areas of aid to dependent children, old age assistance, and aid to the blind.

In this modest cabin, known as "Children's Village" in Immokalee, as many as 30 children are provided with "day care" while their parents work. The children may arrive anywhere from 6 to 8 o'clock in the morning and stay until their parents return which may be late evening. The Village is staffed entirely by volunteers who work under the guidance of the Florida Ministry for Migrants. The children are fed a morning snack of fruit juice or milk, and get lunch each day. If they stay for an evening meal, their parents pay 25 cents extra. This is the second year for the Village.

(Photos by Mel Kenyon, *Miami Herald.*)

A Protestant interdenominational group, the Florida Christian Ministry to Migrants, also has moved into the picture and operates services at 10 points in the State where the migrant problem is heavily centered. Four of these are in Palm Beach County.

The Ministry, which started about 25 years ago on the Eastern Shore of Maryland, now attempts to help the migrant worker wherever he may be, whether on the east coast or in the mid- or far-west.

In several areas the Ministry has day-care centers for preschool children, a recreation and handicraft program for teen-agers, and a depot for migrant women who do not have the necessary maternity clothing.

Religious services are conducted by the Ministry, but migrants are encouraged to go to church in the community if services are held there.

The Ministry also helps with the migrant's welfare problems. A teen-age expectant mother, deserted by her husband, was helped by the Ministry which found and returned the deserting husband, helped locate a job for him, arranged separate housing for the couple, and helped with the woman's confinement arrangements.

The children in migrant families have been described by a Palm Beach County nurse as living "very close to death, birth, and danger."

In the Belle Glade housing camp, a survey was made recently to find out what kind of diets the children had. An astounding number of first-graders reported they fixed their own breakfasts, knew how to make biscuits.

Nutrition is a chronic problem with migrants. In areas where they help pick citrus, the growers have offered them all the fruit they can eat if they will pick it. They do not take advantage of the offer to any great extent. Many of the children get an infinitesimal quantity of milk. In some migrant camps, milk is brought into school each day through arrangement with a local dairy.

Some preschool children, left in the care of older children, are exclusively bottle-fed. Older children eat what is at hand and easy to prepare.

Migrants Not Fully Accepted

Community acceptance also is a problem. In Palm Beach County, some progress has been made in breaking down the barriers between the migrant and the community but the boundary line still exists. Belle Glade children who graduate from the "camp" elementary school and go to the town high school are still called "camp" children, even though the children in other migrant families, living in Belle Glade itself, are accepted in the school as "town" children.

But there is some evidence of a growth in community awareness by the migrants. At the Belle Glade housing project, authorities are tremendously proud of the fact that the camp school has a parent-teacher association—a rarity in migrant settlements—and that a few men attend the PTA meetings.

In some areas, the migrants publicly show how they feel about community rejection. On one migrant worker's hotrod is the scrawled sign: "Don't laugh, lady, your daughter might be in this car."

Southern Florida has recently seen a particularly heavy immigration of one of the four migrant groups, the Puerto Ricans.

The Puerto Ricans were told, in advertisements appearing in Island newspapers, that there was full employment, big money to be made, plenty of housing in the States. They were promised a plane ticket, food, and shelter if they wanted to take advantage of these opportunities.

Many responded to the ads. The persons who promoted this labor importation charged the Puerto Ricans for their plane tickets and for all subsequent expenses they incurred, apparently hoping to make a profit by exploiting them as a labor force. The Puerto Ricans very naturally resented the situation which they found on arrival: few jobs, no housing, no "big money." This situation is being investigated by State law authorities. But the promoters of the scheme already have given Dade County health and education officials a vexing problem.

Some Encouraging Signs

Some of the migrants seem unwilling to take advantage of the meager community facilities which do exist. Families living near the Belle Glade camp in Palm Beach County have been encouraged to bring their preschoolers to the camp day nursery operated by the Florida Ministry to Migrants, yet many apparently prefer to keep their school-age children home to tend to the "babies."

There are, however, among migrant families, increasing numbers who arrive in time to enroll their children in school in the fall and do not migrate again until school is out. These parents seem to place a high value on a high school education. But many other parents place a higher value on the economic asset their children represent during the harvesting season, and not only permit but con-

done their chronic absences from school to work in the fields.

The problem of records is a fretting one to all official agencies who deal with migrants. One boy who finally finished high school in Palm Beach County had been to 17 schools in 5 States during his school life. The principal of the last school was hard pressed to gather the necessary information so he could award the boy his diploma.

Many women who come into prenatal clinics have no record of previous examinations. Those from some northern States can usually show some evidence of previous medical care earlier in pregnancy, because employers in these States encourage them to attend clinics. Most from southern States have had no previous clinic care. Most of the women go back to work in 3 weeks to a month following delivery, usually without a post-partum examination.

Many migrant families, because of their precarious employment, make no effort to follow a budget, and may quickly spend their hard-earned dollars for luxuries without allowing for family emergencies or sickness.

Workers for the Florida Ministry are trying to develop a budgeting sense with some of the women. In addition to teaching them how to add, they also are teaching them how to use a phone, how to read a menu in a restaurant.

Many of the workers, when they get sick, descend on the few available doctors for service, for which a high proportion do not pay, either because they do not have the money or do not feel a sense of obligation.

Palm Beach County health officials believe that if the department staff were augmented by medical social workers, they might be able to tackle the broad problem of medical social services to the migrants, from the standpoint both of regular and emergency medical care and of the individual family's economy.

These officials believe also that all agencies which deal with the migrant problem on a community basis should meet together as an inter-agency group to exchange ideas and information. This pattern, they think, can be applied not only at the community but at the State and inter-State level.

The Size of the Problem

To sum up:

State health authorities in Florida have recognized the problem, but their funds are not adequate to cope with it, and their programs do not meet needs fully.

State education authorities are trying to absorb the migrant child into the regular school system, and where possible are building additional classrooms to accommodate the overflow.

State welfare authorities, under existing requirements, cannot do a great deal to help migrants. Eligibility for public assistance is based on a year's residence in the State, and 6 months in the county.

Assistance to migrants by voluntary agencies is largely limited to the activities of the Florida Ministry.

It would appear that some of the most pressing unmet needs of the migrants and their families are a program of health and general education for both adults and children; some form of welfare aid similar to that which is available to residents; provision of basic housing and sanitation; and a system of exchange of records within and between States so that the migrant worker and his family can achieve more continuity in living.

The community, the official agencies, and the growers need more information about the number of migrants, particularly a figure to show how many migrants join and how many leave the seasonal worker stream each year. They also need a better idea of how many "free wheelers" there are, so that the labor supply can be estimated more accurately.

Each community which has a migrant population needs to recognize that these migrants contribute to the economy of the community, and that therefore the community must share some of the responsibility for them.

These are more or less tangible parts of the picture. So far as the State of Florida is concerned, there is still another factor which may grow in importance. Improvements in agriculture, developments in processing, canning, and quick freezing, and the possibility that rice may become a year-round crop in the State, all may lead to a situation eventually where Florida might be able to offer year-round employment to many of its now migrating workers.

If Florida should solve its migrant problem by absorption, this problem would be no less in other States that have shorter harvesting periods and just as urgent needs for workers.

In all this complexity of social and economic problems, one fact should not be lost sight of: as long as the migrants are badly fed, poorly housed and uneducated, it will be the children who will be most disadvantaged.

"Old hands," now, at using their artificial hands, these 3 youngsters—the boys aged 5, and the girl 3—recently demonstrated before a meeting of the American Academy of Pediatrics that an artificial limb program can help greatly in giving handicapped youngsters the chance for a normal life. Fitted with prostheses by the University of California, Los Angeles, these children have also had treatment at the Marion Davies Pediatrics Clinic in that city. (Photo courtesy of *Los Angeles Times.*)

ARTIFICIAL LIMBS FOR CHILD AMPUTEES

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THERE IS NEW HOPE AHEAD for the child who is missing an arm or leg.

Not tomorrow, or the next day, but in the reasonably near future it should be possible for him to have a substitute limb that will work as efficiently as artificial arms and legs can now be made to function for adult amputees.

Such a prediction could not have been made even 10 years ago. What makes it possible today is the extraordinary progress that has been made for adults under the leadership of the Advisory Committee on Artificial Limbs of the National Research Council.[1]

Since its start, the Advisory Committee on Artificial Limbs has received financial assistance from the Federal Government's Office of Scientific Research and Development, the Army, the Navy, and the Veterans Administration. In 1948 Congress implemented this program on a permanent basis by enacting Public Law 729. This act ". . . to aid in the development of improved prosthetic appliances . . ." authorizes an annual expenditure of $1,000,000 and names the Veterans Administration as the agency to administer the fund. The act also authorizes the Administrator of Veterans' Affairs ". . . to make available the results of his investigations to private or public institutions or agencies and to individuals in order that the unique investigative materials and research data in the possession of the Government may result in improved prosthetic appliances for all disabled persons." By this action, the Congress insured continuity to organization and personnel which was needed if the program was to attain its goals.

Great strides have been made in the last decade in the artificial limb industry. Ten years ago little was known about these problems. The person who had lost a leg could be supplied with a device—or prosthesis, as the appliance is called—that would at least enable him to move about, provided it was properly fitted. But it was another story for the person who had lost an arm. He faced an acute rehabilitation problem. The chances were that he would return to his work—or be forced to seek new employment not requiring the use of both hands—with an empty sleeve, or at best be fitted with a sub-

stitute arm that was little more than a means of deceiving the eye—or trying to.

Today, after 8 years of research and development, artificial legs have been greatly improved and artificial arms have been developed that allow the performance of all the major motions of the arm and hand used in everyday living. This has meant a constant improvement in devices for the control of grasping and of wrist and elbow movements. The goal of all this research has been to make the amputee a 2-handed individual and to provide him with a prosthesis that was comfortable to wear, easy to operate and maintain, and that satisfied the individual functionally and cosmetically.

The cost and time involved in such research ruled out the possibility that any one organization or artificial limb manufacturer could undertake it. It could come about only as it did, through the unique teamwork of government, manufacturers, and professional workers—these last running almost the alphabetical gamut of artists, biologists, chemists, engineers, physicians, physiologists, psychologists, and physical and occupational therapists.

A great deal more research will have to be undertaken before the Advisory Committee on Artificial Limbs working in cooperation with the Orthopedic Appliance and Limb Manufacturers Association can apply the knowledge it now has to the problems of the child amputee. This will involve all the specialists required for work with adults as well as child specialists, the children themselves, their parents, and school authorities.

A child amputee research program, to be conducted at various places in the country, with the Advisory Committee on Artificial Limbs of the National Research Council serving as coordinator, is now being planned. The adult research program already in operation can be expanded to include the child amputee in their study. According to this plan, research would also be conducted by the Michigan Crippled Children Commission at the Mary Free Bed Children's Hospital and Orthopedic Center, Grand Rapids, Mich., and by the University of California, Los Angeles, at the Marion Davies Pediatrics Clinic. Since the start of Michigan's Juvenile Amputee Training Program in 1946, approximately 300 children have received training there in the use of artificial limbs. The project at the Marion Davies Pediatric Clinic is a research program in the developmental problems of the child amputee, started during the summer of 1953, and conducted jointly by the College of Engineering and the School of Medicine of the University of California, Los Angeles.

From the beginning, members of the Advisory Committee were aware that by confining their work to adult amputees a big part of the problem would be left untouched. But circumstances made it imperative that the initial work be concentrated on adults. World War II produced some 17,000 amputees among servicemen. Another 170,000 civilians suffered injuries in war industries that resulted in amputations. They, too, were casualties in the service of their country. These thousands of young men and women needed better help than was available to them at that time.

In 1945 the Surgeon General of the Army made the first move in tackling this problem. At his request the National Research Council set up a Board for Prosthetic and Sensory Devices. After 2 years of investigation and experiment the present program on artificial limbs was organized through the facilities of the Veterans Administration and the Armed Services.

Today research and development are being carried on at the Army Prosthetic Research Laboratory, Walter Reed Army Medical Center; the University of California, both at Los Angeles and at Berkeley; the United States Naval Hospital, Oakland, Calif.; and the Veterans Administration Prosthetics and Testing Development Laboratory, New York City. The New York University Psychological Testing Laboratory is responsible for overall evaluation of devices and techniques under normal conditions.

Two standing subcommittees of the Advisory Committee give general technical guidance, one on lower, and the other on upper extremity prosthetics. Each is composed of specialists in the fields of medicine, engineering, prosthetics, and many other professions that contribute to the rehabilitation of the amputee. These subcommittees review progress, define requirements, and recommend action to the Advisory Committee which in turn advises the Veterans Administration, the Orthopedic Appliance and Limb Manufacturers Association, and others interested in the problems of amputees.

Although the program was set up initially with the needs of veterans and war plant workers in mind, the findings benefit all kinds of amputees. As soon as a device is acceptable to the researchers, it is made available to the general public through commercial

manufacturers. Veterans represent only about 3 percent of the amputee population of this country which is thought to number close to 1,000,000. No count of the child amputee population has been made, but amputation of one or more extremities in children occurs more often than is generally supposed. Some children are born with one or more limbs absent; others suffer loss through accident or disease.

Of the 300 child amputees cared for by the Michigan Crippled Children's Program in the past 7 years, 40 percent were born with limbs missing and 60 percent had lost arms or legs due to accident. The need for artificial arms was 3 times as great as the need for artificial legs.

The first essential in the care of a child amputee is the family, because it is the family who must provide the supervision. It was found in the Michigan program that a child would accept a prosthesis readily enough when his parents were convinced of its importance but that supervision of the child, at intervals of 3 months, was necessary to maintain the prosthesis in repair and prevent the development of bad habits in its use.

A great deal of research which is already benefitting adult amputees lends itself to treatment of the child amputee. In fact, many of the items of the adult armamentarium now available can be used satisfactorily in fitting children. In some instances these items would require no alteration; others would have to be scaled down to child size. But before major gains can be made, research directly relating to children is urgently needed.

Designing child sized hands, small elbow units, and other parts would be the least of the problems. A plastic material that could be remolded, cut, or lengthened as growth occurs might have to be developed. More important still, studies would have to be made to determine which types of hands, wrists, and elbows should be applied to different types of child amputees through various age groups.

Without guidance most child amputees do not wear a prosthesis and reach adult life convinced that they do not need one. For best results children should be fitted at the earliest possible age. Sufficient information is not now available about the age at which a child should be fitted or the type of prosthesis which would be suitable for the young age groups. But many children, both arm and leg amputees, have been successfully fitted under the age of 2 years.

Research, treatment, and training are inseparable and not much is known about the training of very small, handicapped children. It is possible that a simple, glovelike device that enables the child to hold an object against his normal hand would be sufficient at first. A mechanism for grasping that would be safe for a young child to use would come later. More complicated prostheses involving wrist rotation, elbow locks, and finer manual dexterity would be added as the child's motor development made them advisable. Training would have to take into account the physical, mental, and psychic development of each individual child. It would involve cooperation of the parents who themselves would need special guidance. In the case of an infant, training would be directed to simple tasks, and as the child grew, to the more difficult motions involved in self care, play, and later in work. This would mean selecting tasks that are possible for the child to perform at various ages, motivating him to perform these tasks, and supplying him with the mechanical aids which his age and development permit him to operate easily. The facts can only be learned from experience in fitting and training child amputees.

Biomechanical studies as they relate to children would have to be made. All improvement in prosthetic replacement grows out of such time and motion studies of normal persons and amputees. Beginning early in the adult program, and in continuous progress ever since, arm movements made by a normal person and those made by an amputee wearing a prosthetic device have been investigated. These studies brought to light a wealth of needed information. They revealed altered or substituted gestures that are peculiar to the amputee. They also showed differences in speeds, forces, and skills. While a great many of these facts are immediately applicable to children, more specific information would have to be gathered as the program expanded.

The psychological impact of the loss of a limb varies somewhat with the individual. It may also vary with the age of the child and the attitude of his family. The full import of such a loss is not known and psychological studies would have to be made. Does the child's injury tend to make him withdrawn or antisocial? Does it inhibit the normal development of self-confidence and independence? To what extent does the prosthesis meet these problems?

Experience in the adult program has shown that the most effective service to the amputee can be given

The prosthetic research program for child amputees, projected in this article, can build on effective work that has already been done with a few children, and multiply and improve it for the benefit of many. This small bilateral amputee, less than 3 years old, shows that even very young children can be fitted with prostheses and do most things normal children of that age do. As he grows older, this youngster can be fitted with wrists and hands which the projected research program is expected to perfect and test.

only through a prosthetic clinic with a physician, physical and occupational therapists, prosthetist, and other consultants if needed, acting as a team, consulting together with the amputee and sharing their knowledge and skills toward his rehabilitation. In fitting adults it has been found that many circumstances have to be taken into consideration. What type of amputation does the patient have? How well is he able to use the stump of his arm? How strong is it? Is his physical condition good? What type of work is he in? What is his attitude toward wearing a prosthesis? Considerations such as these and many others have to be evaluated before the prosthetic prescription can be written. This requires the services of a team.

The physician serves as the head of the team. The type of service and prosthesis is usually arrived at through consultation of all members of the team but final prescription is the physician's responsibility. The physical and occupational therapists are primarily responsible for the therapeutic exercises and training the amputee in the use of the prosthesis, as prescribed by the physician. The prosthetist fabricates and fits the prosthesis as prescribed. Each child prescription team would have as members, in addition to these workers, a psychologist or a psychiatrist, and a medical social worker.

The team is also responsible for checking out the prosthesis, for seeing that it meets certain standards and that the amputee is able to use it effectively following training.

But the study does not end when the amputee has been fitted and taught to use his prosthesis. The Advisory Committee found that they could not always get dependable answers from the adult amputee, after he had been using his prosthesis under normal home and work conditions, to such questions as: How valuable in this prosthesis? What can the wearer do with it? What can't he do with it?

Some measure of performance was needed. To develop such standards, another facet of the artificial limb program came into being.

Today adult field studies are conducted on a Nation-wide scale under the supervision of the Prosthetic Devices Study, New York University, to determine whether a prosthesis which was judged satisfactory under controlled, laboratory conditions stands up under normal, daily living conditions. Before any device is given final approval and recommended by the Advisory Committee, it is turned over to New York University to be given a field test.

Followup evaluation tests applicable to children would have to be developed for the determination of prosthetic functions. These would be similar to the tests developed for the adult amputee, although undoubtedly they would be more complicated and more difficult to apply. Children would probably have to be followed until they reach maturity. Adjustments and replacements for the prosthesis would be made as needed.

Releasing the device to the public is not enough. Teams of physicians, physical and occupational therapists, and prosethetists must also be trained to apply the research knowledge. A school in upper extremity prostheses was established at the University of California, Los Angeles, in 1953 to train the various types of specialists needed. Ten complete courses have been given to date to teams from selected cities. In the future additional courses will be offered to any teams who want this training.

The California school grew out of a pilot study made in Chicago in 1952. A group of Chicago physicians, therapists, and prosthetists first attended a course in upper extremity prostheses at the University in Los Angeles. When they returned to Chicago a clinic was established which processed 50 amputees, applying the knowledge learned in California. Each amputee's problems were evaluated before and after clinic treatment by a prosthetic team.

A most encouraging fact that came to light in the Chicago study was that 80 to 90 percent of the arm amputees who received team service through the clinic continued to wear their prosthesis. This was also revealed in the Case Study Program which was conducted at the University of California, Los Angeles, in 1950. Psychologically, the amputees showed much improvement and their ability to handle their prosthesis had greatly improved.

A prosthetic program means much more than fabricating prosthetic devices. It means the ability to prescribe the device that will best satisfy the needs of the individual. It means training the amputee to benefit from the maximum functioning of the artificial part. It means helping him to adjust psychologically and socially to his handicap. It is a completely individualized service. And it requires the cooperation of innumerable experts. Work of this kind cannot be carried on by individuals working in isolation. But a program for children can build on the accomplishments for adults which have behind them the full resources of the nation.

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[1] The Council is a technical body, established in 1916 by the National Academy of Sciences, which operates under Congressional Charter. The Council is charged with the responsibility of "conducting research in the mathematical, physical, and biological sciences, and in the application of these sciences to engineering, agriculture, medicine, and other useful arts." Its membership includes not only scientists and technicians, but also businessmen interested in engineering and industry. The Academy and Council are cooperative, quasi-governmental agencies and their research work is financed by the returns from endowment funds, by special grants, and by contracts with other agencies.

"MOVING AHEAD TO CURB JUVENILE DELINQUENCY"

THIS IS THE THEME of a conference which has been called by Oveta Culp Hobby, Secretary of Health, Education, and Welfare, for June 28–30 in Washington, D. C.

The conference will climax 2 years of preparatory work by the Children's Bureau and the Special Juvenile Delinquency Project sponsored by the Bureau.

Purpose of the conference is to review accomplishments to date; define and discuss the most urgent needs at this time; and formulate next steps in a continuing program to meet those needs.

The opening general session will be addressed by Mrs. Hobby, and by the Hon. Robert C. Hendrickson, Chairman, Senate Subcommittee to Investigate Juvenile Delinquency. The Chief of the Children's Bureau, Dr. Martha M. Eliot, will chair the opening session.

Two of the three conference days will be devoted to detailed study in 13 work groups on these subjects:

I. *Knowledge to Prevent Delinquency*

II. *Parents' Role in Preventing Delinquency*

III. *The School Faces Juvenile Delinquency*

IV. *Counting Delinquent Children*

V. *Police Services for Children*

VI. *Providing First-Rate Detention Care*

VII. *Juvenile Courts and Probation Services*

VIII. *Our Institutional Treatment Program*

IX. *Coordination of Services for Delinquent Children*

X. *Training Personnel for Work with Delinquent Children*

XI. *Citizen Action to Curb Delinquency*

XII. *Moving Ahead for Sound State Legislation*

At the final session of the Conference, a summary of findings will be adopted by the group.

A number of basic Bureau-Project working papers or pamphlets will be available to the conferees for their discussions.

Invitations have gone to persons who have been working on the Bureau-Project program over the past 2 years. They include public officials, and representatives of cooperating educational, religious, civic, fraternal, health, and labor organizations, as well as of professional groups.

It is anticipated that 400 specialists will be in attendance.

CHILDREN will report in a later issue on conference results.

District of Columbia uses medical social services in child health clinics in . . .

HELPING MOTHERS HANDLE EMOTIONAL PROBLEMS

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FOR MANY YEARS one of the major tools of the maternal and child health program has been the child health conference or clinic. Increasingly these clinics are places where parents may receive help with the early social and emotional difficulties of their children as well as with their physical health.

The Bureau of Maternal and Child Health of the District of Columbia Department of Public Health put this concept into action very early in its work with mothers and children. The medical staff of that Bureau recognized that social difficulties within the family often threatened the care given the child or created emotional tensions and problems within the child which interfered with the normal process of growth.

For this reason, the Bureau, shortly after its establishment in 1936, added medical social workers to its staff to help with these problems. From almost the start of the program, casework services from a medical social worker have been available to these clinics, first intermittently, later on a regular basis.

During the years, the Bureau and its staff have greatly increased their understanding of the effect that social and emotional difficulties within the family have on the growing child. This article shows the types of emotional and social difficulties encountered in the clinics and how the medical social worker helps the mother with these difficulties—help which in turn benefits the child.

The emphasis of the medical social worker in the child health clinics of the District of Columbia is primarily on helping with those social and emotional problems that interfere with the normal, healthy development of the child. Her activities may include direct social casework services to parents and children and consultation with other staff members and other community agencies. She merges her services with those of other professions in maintaining the physical and emotional health of the child.

The District has 15 neighborhood child health clinics offering health supervision to preschool children. The Bureau of Maternal and Child Health has a small staff of medical social workers headed by a director of medical social service; one medical social worker is assigned to these centers. This means, of course, that coverage is limited, but referrals for social casework services are made to this worker from all the centers.

A large majority of the families using the child health clinics are in the lower socio-economic group and have all the problems usually present in this group, such as substandard housing, and inadequate and frequently irregular incomes. Many are individuals with a long history of deprivation. Often these mothers come from broken homes and have never had an opportunity to develop a warm enduring relationship with another person or to develop their innate potentialities.

In these centers, the physician's health appraisal includes a developmental evaluation of motor, adaptive, and social behavior, language development, and personal habits. The physician evaluates whether or not behavior and development are within normal limits for the child's age and discusses this with the mother when this seems desirable. The public health nurse also sees all the mothers and discusses these things with them. Through this educational process many mothers become well informed about what can be expected of a child at various age levels. But as valuable as instruction is, it does not meet the

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problems of mothers who are upset about personal difficulties or have problems in their families that make it impossible to absorb the information available to them or even to use the knowledge they have.

There are many ways in which medical social workers help these mothers. They help the mothers with their use of the services in the clinic, with difficulties in family relationships which are affecting the development of the child, and with the early recognition of tensions in relationships. They also identify deepseated difficulties and assist mothers in accepting help if such help is available on a sustained basis. Through such help to the troubled mother, stresses and strains are eased, solutions to some problems are achieved, and, in the long run, the child's situation is improved.

In some instances the mother's and child's needs are such that service from another community resource is essential, if they are to have help. In the District the usual social agencies present in large cities are found. As in most social agencies in the country offering skilled services there are long waiting lists, not enough funds to cover all needs, and not enough trained workers. As a result, the best than can be attained is some improvement in the situation.

What are the problems mothers bring to these centers—problems to whose solution medical social workers offer help?

Sometimes an insecure, upset mother may respond to advice regarding the care of her child as if she were being criticized for what she is doing or failing to do. For example:

One young unmarried mother was referred to the medical social worker because her child was malnourished and was not gaining weight despite the efforts of the center to help her with this. The medical record showed that the mother was usually very upset in the clinic and frequently cried. She had said that she could not afford to buy the foods recommended for the child by the center. She was on the verge of tears when she came for an interview with the medical social worker. Although she had been referred for assistance with financial problems, she said she did not need such money and remained totally uncommunicative about what was really troubling her.

Finally the worker commented that something must be wrong since she seemed so upset. The mother started crying and between her sobs revealed that she did not want "to be bothered all the time."

"What is it here in the clinic that bothers you?" the worker asked. Eyes cast down, the mother said slowly, almost in a whisper, "They keep telling me that the baby isn't doing well; I know he isn't doing well, I know that, but I don't want to be told this all the time. I'm doing everything they tell me."

The worker asked if the recommendations had sounded like criticisms to her. "My friends keep asking me why I come since the people here keep saying things to me all the time," she replied.

"It isn't that I haven't had the money to do it—and I've followed the doctor's suggestions in feeding him. It isn't my fault that he doesn't gain."

Evidently the mother had construed the suggestions made by physicians and nurses as criticism of her care of the child. Her way out apparently had been to say that she did not have the money to follow through on these recommendations so they wouldn't think she was an inadequate mother.

The worker commented, "The doctors and nurses are concerned and want to help you. You seem worried and upset and perhaps this makes it difficult for you to care for the baby—and he may be reacting to the way you feel, too."

This last remark seemed to free the mother enough to talk about things that were bothering her. She started to talk about the father of the child—and immediately became quite choked up with feeling. He was living in another State and was showing no interest in her or the child. At this point the mother was unable to go on.

Because this mother was so deeply disturbed and unhappy the worker knew that many months would be required to help her feel less anxious.

In preparation for the mother's next clinic visit, the worker talked to the doctor and the nurse about the mother's feelings and her need for reassurance and encouragement.

On the next clinic visit two weeks later, the child showed an appreciable gain in weight for the first time in 3 months, and the mother was commended on the child's improvement. The clinic recommended that the child get a special, rather expensive type of milk and the mother accepted financial help with this for one week. Later she arranged to take care of this responsibility herself.

The next visit showed the child had continued to gain weight and the mother expressed surprise and pleasure with this improvement. She seemed much more relaxed and listened carefully while further recommendations for the child's care were discussed. She was very proud of the child's improvement and the staff's recognition that she was responsible for it.

During the last two interviews and the ones that followed, the mother was able to talk more freely. She stated that she was very hurt that the father did not marry her after she became pregnant. Since she had been talking with the worker, she was feeling better than she had for a long time and she thought it best that she try to forget about him. This affair had "messed up" her life and ruined her plans for an education. She had returned to school after the birth of her child but was unable to continue because

she had no one to care for the baby.

The worker wondered whether it might not be possible to work out plans in the future for the mother to go on with her education. The mother brightened at this possibility and said she certainly would appreciate any help the worker could give her with such plans.

Although all the mother's problems had not been resolved, she had been freed to talk about the things that prevented her from giving good care to the child. The worker's non-blaming and understanding attitude had relieved her tension and made it possible for her to be less tense with her baby. The baby in turn responded to the changes in his mother and gained weight. The worker would continue the interviews with the mother until she gained more confidence in her ability to meet her own problems and plan for the future.

Many mothers are concerned about thumb sucking, nail biting, masturbation, feeding problems, aggressiveness toward a younger child, whining, and negativism. The worker can evaluate the behavior with the mother and help her determine whether the behavior is within normal limits, in which case the mother feels reassured by the interview and feels that "talking it over has helped me," as one mother commented after an interview concerned with the symptoms of jealousy her 2-year old was showing.

Most mothers understand jealousy when it is expressed directly through overt action, for example through the child's attempting to push the baby off the mother's lap or wanting to be held whenever the baby is held. But they do not always understand so well a child who shows his jealousy indirectly by regressing in toilet training or wanting a bottle again after having been weaned without difficulty some months previously. Sometimes they are not quite sure how they should handle a child who shows love for the new baby 1 minute and the next minute wants to hit him in the face.

Some mothers may not recognize a behavior difficulty or may be reluctant to admit to themselves that any exists. Others may express concern about the behavior and seek some simple treatment in the form of easy-to-follow advice that will clear up the situation. Even when mothers recognize the symptoms, often they have not yet reached the stage where they consider the behavior serious enough to be seeking help and may not have thought of the clinic as a place where emotional as well as physical factors are considered.

Behavior problems of children in the child health clinics have ranged all the way from the relatively common but sometimes excessive jealousy an older child feels toward a new baby to the psychotic behavior of a 4-year-old who finally had to be admitted to a mental institution. The latter, of course, is exceptional. Most of the problems encountered are excessive manifestations of a normal trait of behavior at a given age which might be considered abnormal at a later age, if no help were given.

Often behavior which in itself may not seem grossly abnormal may be indicative of serious disturbances in the life of the child. For example:

Three-year-old Mary was whiney and apprehensive in the clinic, constantly clinging to her mother. The mother reported that Mary had a poor appetite, did not sleep well, and complained of pains. Upon examination the doctor found no physical basis for these symptoms. Suspecting that the root of the difficulty lay in the home situation, the doctor referred the mother to the medical social worker.

The mother said that Mary is an only child, so has no playmate in the home. She is not allowed to play much with other children because her parents say that she does not get along with them and sometimes they hurt her. She cries if her parents leave her with someone while they go out, so the father refuses to go anywhere unless Mary can go with them. Mary is the center of attention at home and her parents can hardly let her out of their sight. They have her sleep in their room because they do not want her too far away from them. The mother said that the father is critical of her if Mary hurts herself slightly, saying that she should have watched Mary more closely.

The mother seems almost as protective of Mary as her description of the father but is beginning to feel very tied down. She expresses some resentment about the father's attitudes toward Mary and herself. The mother said she felt the father was losing his interest in her. He was concentrating entirely on the child and giving her all of his attention. The mother was doing everything she could for the child and was really trying to care for her the way the father wanted her to. But no matter what she did, her husband was still critical of her.

She admitted a good deal of dissatisfaction with her own life, too. Before Mary came, the mother had held a fairly responsible job—and her husband had seemed proud of her and interested in what she was able to do. She says that she does not have enough to do now and the responsibilities she does have are not stimulating enough. Because she had come from another State fairly recently, she has few friends and is practically without interests outside her home. Financially she does not need to work but she is thinking of finding a job to occupy at least part of her time. At this point the worker asked, "Is this really why you want to go back to work?"

The mother thought for a moment and came back with, "I really don't know! When I think about it, I know I really have enough to do at home. Ac-

tually I'm busy all the time." The worker asked, "Do you think your husband would have more respect for you if your worked?" The mother looked a little startled; then said, "Maybe so." "Perhaps this is why you feel tied down and resentful of your husband's attitude toward Mary. It must seem to you that he thinks Mary is more important than you are," the worker said. The mother didn't answer but seemed to be busy with her own thoughts.

The worker asked whether she thought children Mary's age really needed their mother's care and whether this responsibility was an important one. The mother nodded her head in agreement.

As the worker and the mother went on discussing young children and the possible causes of Mary's behavior, the mother was able to say that she thought Mary was responding as she was because of the way she and her husband had been handling her; maybe Mary's difficulties went back to the relationship between them. The mother guessed that she, herself, had been holding Mary too close because she was unhappy in her relationships with her husband, and Mary bore the brunt of this. For the first time, the mother seems to be able to look at Mary and her needs as a growing child.

The mother, once having recognized the situation for what it was, could accept responsibility for it and do something about it. At a later interview, the mother reported that she and her husband had talked things over. She had decided not to go back to work. These were important years in her child's life and in the lives of her parents. They were trying to give Mary more opportunities to play with other children. They had invited a neighborhood youngster into the home to play and Mary seemed to get great enjoyment from this. Clearly Mary's problems were not all solved but progress had been made and the way was open for further work with the mother.

Another 3-year-old was referred to the medical social worker by the physician because the mother was concerned about his behavior.

Johnny sucked his thumb, masturbated, and had a speech difficulty. She thought Johnny's difficulties dated back to the time when she had had to return to work because she had separated from his father.

She had had a child prior to her marriage to Johnny's father and had always felt quite guilty about this. "The bottom just dropped out of everything" when she learned she was pregnant and she had never really been quite happy since. The grandmother had always cared for this older child.

After her marriage to Johnny's father, the mother soon found that he would not assume financial responsibility for the family as she thought he should. By the time Johnny was born, they were separated. She returned to her mother's home and was quite miserable because she felt she was a burden. At first she had been getting public assistance but this was stopped when the father had indicated he wanted a reconciliation. The mother, feeling that he had not changed fundamentally, did not wish to go back to him.

The father had not supported them adequately while he was in the home and, since the separation, had given only a small amount toward Johnny's support and then only after she had taken court action. She was resentful and disappointed in her husband and upset because she could not give her children the supervision and companionship she felt they needed. Everything seemed quite hopeless to her.

It is at this point she decided that the only thing she could do was to get a job. Immediately Johnny seemed upset, would not eat, lost weight, and became quite withdrawn. Because she suspected that Johnny was not getting enough attention, she arranged to have an aunt who was fond of him care for him. She thought that his behavior had improved some since this arrangement was made but she still was not entirely satisfied. She did not completely approve of the way he was being handled by the aunt. She felt that neither his aunt nor his grandmother had much understanding of a young child's needs.

Johnny was the only boy on the mother's side of the family and all his adult associates were women. As the only boy, he had received a great deal of extra attention; but not all of this was helpful. Sometimes it took the form of teasing about his being different. The mother was aware of these problems but did not know how she could control them completely.

Because of the undesirable effect this type of social situation was having on the boy and because he needed companionship with children of his own age, the worker suggested that nursery school would be a good experience for him—and the mother agreed. The worker helped the mother make arrangements for Johnny to attend a nursery in one of the settlement houses.

The worker, realizing that nursery school placement would not solve all of Johnny's problems, offered continuing services to the mother. She and the mother would see how Johnny responded to nursery school. If this did not work out satisfactorily, some other arrangements would have to be made. His mother will need sustained casework help in coping with her heavy parental responsibilities alone and in working out some of her own difficulties.

Occasionally, of course, medical social workers find mothers who are faced by situations so difficult that good care for the child is practically impossible for them to attain. For example:

Peter who was doing very poorly was referred to the medical social worker with the suggestion from the physician that if the home situation could not be substantially improved, perhaps the child should

be placed outside the home temporarily so that he could be built up to the place where he might be able to get along. All efforts to help the mother improve the care to her children had failed up to this point.

The mother was a somewhat limited individual who might have been able to manage her home and children satisfactorily under less difficult circumstances, but an interview with the worker showed that she was overwhelmed by her responsibilities. The family's housing was deplorable, which made care of the children very difficult. The mother recognized that Peter was malnourished and poorly cared for but was too discouraged to do much about it. She had a large family of six children and the father was not able to earn enough to support them at a decent level. Her own responsibilities in caring for the children seemed too much for her to handle and she was resentful toward the father for not recognizing this and helping her during his off hours.

She said she actually had had "three babies" to care for during the last few weeks. Peter, the child referred by the doctor was about 6 months old; the 6-year-old child had recently broken his leg so he was in a cast and an 8-year-old girl was so retarded mentally that she was completely helpless. There was no money to pay for even part-time help for the mother.

A recommendation that the retarded child be placed in an institution had been so bitterly opposed by the father that no application had been made. The mother said she thought his attitude was changing. The worker suggested that perhaps things would be easier if Peter were out of the home for a while. The mother agreed that with Peter out of the home, she could start making arrangements for placing the little girl in an institution. Even though she gave the impression of being fond of her children and wanting them with her, she was willing for Peter to go away temporarily. She said that it seemed the best thing to do because she could not give him the care he needed.

The worker was able to arrange through a child-placing agency for Peter to go to a foster home for 3 months where he gained weight rapidly and otherwise made good progress. During this time, the retarded child became ill and died.

The worker encouraged the mother to talk about her feelings about this, realizing that the sense of guilt many parents have about an abnormal child may be intensified when the child dies, particularly if the care the child received was not the best. The mother admitted she felt guilty about the child's death and resentful toward the father. Perhaps if he had permitted the child to go to an institution, she might still be alive. The mother felt that he was blaming her because she didn't do a better job in caring for the children. She had done the best she could under the circumstances. During the interview she said that perhaps it was better that the child had died because she knew the little girl's condition would never have improved.

While Peter was out of the home, the 6-year-old child's cast was removed so he was able to walk again and thus relieve the mother of extra care. After this, the mother was able to make some improvements in her home situation. She found much more satisfactory living quarters which made her housekeeping responsibilities lighter. Shortly thereafter she got a part-time job to supplement the father's income and a relative moved into the home to care for the children while the mother worked. When Peter was finally ready to leave the foster home, the mother was enthusiastic about his returning home. She felt she was now in a position to provide for him. Later clinic attendance showed that he was doing well.

For whatever reason a mother or child is referred to the medical social worker, the worker in the child health clinics is sensitive to the mother's emotional reactions and the ways in which she expresses or disguises her feelings about the child. While working with the mother the worker observes the child's behavior and his relationship to the mother. In all her interviews she is alert to any family and other interpersonal relationships which may affect the child's development.

In the course of her study of the mother, the child, and the family, the medical social worker contributes her knowledge of their social needs to other members of the staff so that these can be taken into account when planning for the care of the child and when carrying out that plan.

Through social casework the medical social worker gives the mother a feeling of acceptance and understanding which may increase her ability to care for the child. She accepts the mother's attitude which may involve hostility or indifference toward her child. She tries to show the mother that she is aware of the many difficulties confronting her and to help her with them. She considers what there is in the mother's marital and family relationships and in the mother, herself, that must be taken into account before the services offered by the clinic can be truly helpful to her and to her child.

In many instances, the medical social worker recognizes that the mother's and child's needs can be met only through the collaboration of other community agencies—and she then uses her knowledge of community resources to help the child and his family.

Some of the developments in the child health centers of the District of Columbia give evidence of the ways in which medical social workers can contribute to child health clinics in providing services to meet the emotional and social needs of mothers and children.

A lawyer and a social worker look at . . .

STANDARDS FOR SPECIALIZED COURTS DEALING WITH CHILDREN

OVER 30 YEARS have passed since the first recommended standards for juvenile courts were adopted jointly by the National Probation Association and the Children's Bureau and issued by the Bureau.[1]

Now, in June 1954, the Children's Bureau is releasing an entirely new statement of standards for courts dealing with children which have been developed by the Bureau, this time in cooperation with both the National Probation and Parole Association and the National Council of Juvenile Court Judges.

Although the juvenile court movement is more than 50 years old, difference of opinion continues to exist on what the function of such a court should be.

Some have felt the court should operate a broad program for the treatment and care of children, similar to programs of public and private welfare agencies. Others would either drastically limit or remove the court's treatment functions.

The new "Standards for Specialized Courts Dealing with Children"[2] attempts to define which treatment functions are appropriate to such courts and which are more appropriate to administrative agencies in the community.

Six major points are made in the 1954 Standards:

1. Due process of law is just as applicable to the procedures in a children's court as it is in any other court. The right of a child to live with his own family and the rights of parents to the care, custody, and control of their children are paramount and these rights should be limited only through due process of law under clearly defined conditions. In observing due process of law, a specialized court dealing with children must keep its procedures flexible, and maintain the basic philosophy of the court which is to treat, not punish, the child.
2. The powers of the court should not be drastically limited or removed. If the court does not have power to dispose of cases, the alternative is to give this power to an administrative tribunal or panel, such as a clinic or a committee of experts and lay citizens. The document rejects use of such alternatives.
3. Unlimited discretion should not be placed in any judicial officer to do as he sees fit with any child. Such discretion is now allowed in many statutes which, in outlining the powers of disposition, permit the judge to "order such other care or treatment as the court may deem best." Statutes should specify a number of types of disposition that may be used by the court and permit flexibility in their use.
4. All parties coming before the court have a right to know the facts on which the court makes its decision. The public has a right to know about the general operation of such a court, but not at the expense of the privacy of the individual child and his family.
5. The parent and child have a right to legal counsel in proceedings in the specialized court and, under certain conditions, counsel for the child or the parents should be appointed by the court.

6. An administrative agency should be able to take some actions with respect to a child placed in its custody without recourse to further court order. Commitment, for example, is not now clearly defined in some statutes as to what rights the parents keep, to what extent their rights are limited and placed in an administrative agency, and what power is still held by the court. The standards define these terms more precisely to set out the rights, duties, and responsibilities of all parties to an action involving a child, including the child himself, his parents, the agency, and the court.

"Standards" was developed under the direction of William H. Sheridan, Consultant on Juvenile Delinquency to the Children's Bureau. The task of collecting and organizing background source materials, preparing initial drafts, and assisting in later revisions was entrusted to Alan Keith-Lucas, Associate Professor, School of Social Work, University of North Carolina. Substantial contributions to the evolution of the concepts and procedures suggested in this document and to its preparation were made by Herbert Wilton Beaser, formerly Chief, Children's Bureau Branch, Office of the General Counsel, United States Department of Health, Education, and Welfare, now Assistant Counsel, United States Senate Subcommittee Investigating Juvenile Delinquency, and by Sol Rubin, Legal Consultant, and by Will C. Turnbladh, Executive Director, of the National Probation and Parole Association.

What the new principles may mean to the 2 professions most immediately concerned with the operations of juvenile courts—lawyers and social workers—is discussed in the papers which follow.

A LEGAL VIEW

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SOME READERS may find a major point of interest in the amount of water which has flowed under the bridge since 1923 when the Children's Bureau issued its initial Bulletin on *Juvenile Court Standards*. Others may focus attention on the bridge itself. This bridge, of course, is the one designed to span the social distance between the fields occupied respectively by social workers and lawyers.

A comparison of the simple quantity of the water in 1923 and in 1954 as such is not presently pertinent. Our concern is with more complex matters: content and direction. The 1923 pamphlet was prepared under the auspices of a Committee of distinguished experts representing the United States Children's Bureau and the National Probation Association. The 1954 booklet on the other hand was produced by a small team of experts, and later examined critically by a larger group. "This group of about 30 persons included judges, probation officers, child welfare officials and others representing the fields of law and social work. In addition, the draft was distributed to about 150 persons throughout the country representing the same fields."

One who reads the two pamphlets in terms of content will note that by comparison the former, today, seems both oracular and thin. It is oracular because the standards are promulgated and the reader is asked to accept them as authoritative on the faith of the proponents.

The latter pamphlet recognizes impliedly the force behind the principle long familiar to lawyers that "the law is unknown to him who knoweth not the reason thereof." It gives reasons. It enables the reader to debate the points in his own mind with the benefit of some of the material available to the writers. Thus, the new volume should make headway by virtue of its own reasonableness.

Again by comparison, the 1923 collection of materials today seems thin. One may liken it to a two-dimensional picture. It gives the reader the rules. To the reader who is already an expert this is perhaps all that is necessary. To the nonexpert, the person who is to be informed, whose intelligent support of the juvenile court movement is sought, it offers what we may describe as an expert's shorthand. The 1954 volume gives us a picture not only of rules, but more of a three-dimensional juvenile court. We see more clearly the staff and the community functioning, each staff member in his own office, and at the same time in his contacts with others within and without the court. 1954 is a far more human document.

Some of us would like to be around in 1984 in order to have a glimpse of the publication to be issued in that year. No doubt some future reviewer will consider the present material as merely a report of progress.

As examples of these differences in content, it is possible to comment briefly on two items. In the 1923 publication, the concise statement is made: "1. There should be available to every community a court equipped to deal with children's cases."

The interested reader is left to explore the significance of that sentence in the 10 pages of the report or elsewhere.

In 1954, the first item on the reader's agenda is an explanatory section entitled the "Philosophy of the Court." The words "individualized" or "specialized" are used. They show us at once that whatever mental picture we may have of an orthodox court we should not allow ourselves to apply it automatically to the present setup. Here is something special.

Again in 1923, the material on "Probation and Supervision" includes a paragraph on the minimum qualifications of probation officers. This paragraph is a little over four lines long. In 1954, the additional space devoted to probation work suggests that our knowledge on the subject has increased. References are made in footnotes to other material not in existence in 1923. Consideration is given to the method of selection, responsibility, a program for continuing education of probation officers. A reference to "civil service or merit system rights as to tenure, salary, promotions, bonus, *etc.*" indicates that these workers as well as the children for whom the court is established deserve consideration.

On the matter of direction, the 1954 publication is addressed to a wider circle of persons including those who should be interested. Here the pamphlet makes a most significant contribution in the field of social engineering, or, if you will, bridge building.

Between the fields occupied respectively by persons trained according to the disciplines of social work and law there is an interstitial gap. As civilization becomes constantly more complex it is easy for each group specializing in its own field to learn more and more about less and less. No one is so imaginative as to assume that eventually each of us will know everything about nothing. But the only safeguards which will insure that we do not drift into that form of isolationist catastrophe are dependent upon our intelligent efforts to bridge the gap. At present, the legal aid society is one bridge anchored in the field of law and gradually making its way toward social work. The juvenile court, by and large, may be considered as a bridge originating in the field of social work and moving steadily, if not too rapidly, toward an accord with law.

The present booklet chronicles not only the progress made but some of the obstacles which are encountered by proponents of accord and which must be surmounted. A few of these may be mentioned in passing: the lack of a vocabulary intelligible to both groups at once; the mental blocks arising from differences in educational discipline; the understandable conservatism of vested interests.

As far as vocabulary is concerned, it is clear that each profession normally employs a shorthand of special words, phrases used with special significance, key concepts. A stranger encountering these words, phrases, and concepts and not realizing the setting in which they are used is likely to attach to them his own meanings, and to draw therefrom inferences perhaps quite afield from those intended by the users. The 1954 booklet at the very outset is faced with a decision as to one of these words. Shall it call the court a "socialized" court, after the usage of former Dean Pound, or something else? To persons trained according to the social work discipline, "socialized court" is in the nature of a proprietary label like "made in America." They point to it with pride. To the lawyer who is not familiar with the special usage, the phrase conjures up more or less vague visions of foreign ideologies, socialized medicine, and the like. Consequently the term "specialized" or "individualized" court which is equally accurate is far less provocative. It does not need to be explained. Again to the lawyer, phrases like "legal custody," "guardianship of the person," "residual parental rights and responsibilities," "probation for children," "protective supervision," "aftercare supervision," "detention and shelter care" have a general rather than a specific and distinctive significance. Comparatively few of these terms have been defined by the opinions of judges of appellate courts and for the lawyer it is the judicial opinion that represents authority.

The pamphlet spells the specialized meaning out in detail. One can hope that many cases involving the functioning of juvenile courts may in the future be taken up on appeal. By this process not only will the law thereby be clarified but the definition here enunciated will receive attention and, one may hope, legal sanction.

The bulletin does not contain specific evidences of differences in educational discipline and of the conservatism of vested interests but it is refreshing to read toward the end the emphasis on the need for removing the occasional "open distrust of the court by lawyers." It is not likely that any such lack of

confidence will eliminate itself. The program for removing it, one suggests, should be preventive as well as remedial. Schools of social work offer courses in law. Schools of law should be encouraged to offer courses in social work. There, *in limine*, many grounds for possible disagreement may be ironed out.

Everyone should welcome this book. It brings the problem out in the open where we can all take a look at it. It inspires us by the record of achievement in a short 30 years. It challenges us to see if the next 30 can be made equally productive.

A SOCIAL WORK VIEW

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HISTORICALLY *Standards for Specialized Courts Dealing With Children* is long overdue. It is one of the most important publications in the field since the first juvenile court act itself.

Few social workers will be able to examine *Standards* without a sense of excitement and satisfaction. It puts together the best in experience, knowledge, and understanding, for a clear blueprint of the specialized court with its great helping potential for the thousands of children who come within its jurisdiction.

This, however, is not the sole contribution of *Standards*. Out of the very process of setting down principles which reflect advances made in the juvenile court field and increased knowledge of child care, there has been created, perhaps unexpectedly, an integration of what have often been considered two separate and incompatible entities: the administration of the law, and the giving of social services to the troubled child and his family. This integration has been achieved, in part, by clarifying the essential nature of the court as an instrument of nonpunitive justice, individualizing the situation of those who come before it and protecting the legal rights of the persons involved in that situation.

Additionally, however, in spelling out the details of how this kind of court might best operate, its processes have been conceived as requiring the provision of a helping service directed toward full and responsible participation by those who serve as well as by those who are served. A blueprint which achieves so much is hardly less than magnificent and the significance of *Standards* will become increasingly apparent over succeeding years.

Despite the foregoing, there will be some persons who will not be immediately pleased with the whole of *Standards*, or willing to accept them. Those with legal training will be quick to identify with and approve the emphasis on the protection of the individual's legal and constitutional rights which are so often overlooked in juvenile court practices. The social worker will be as quick to identify with the parts of the work directed toward meeting the needs of children and their families which likewise have been often overlooked. Paradoxically, the former may have difficulty in assenting to, for example, the limitation on the powers of disposition accorded the court. The limitation, nevertheless, embodies the substance of the protection initially approved. Conversely the social worker, who will welcome the clarity of the proposed principles of disposition, may have some difficulty—in his haste to get on with the important task of helping the child in trouble—in understanding the insistent emphasis on due process of law.

Why the paradox should exist in each instance is worthy of some consideration for a careful perusal of *Standards* reveals that the protection of legal rights is viewed as a prerequisite for meeting human needs, and the meeting of human needs is seen as a prerequisite for the protection of legal rights. What may initially stand in the way of such recognition by readers of *Standards* is, perhaps, a deeply human problem shared in common despite the differences in professional backgrounds. That problem is concerned with the use of one's own self when addressed to any complex matter involving the substance and nature of another person.

The problem of judges, for example, who impose their own personal and arbitrary religious and moral ideas on those who appear before them is well known to social workers and court practitioners. Interestingly enough, while such impositions can be held to be as much of a violation of the client's rights as the failure to provide any constitutional guarantees, there is little, if any, legal structure or even training designed to prevent such violations. The law simply

assumes judges will not so act. While the law always stresses individualization, accepts the concept that there is room in society for all kinds of differences in behavior, and insists that it must be shown beyond a reasonable doubt that the person charged has actually violated the law, the law itself cannot prevent the exercise of personal ideals or attitudes of a judge, if the latter chooses to impose them.

The child is a particularly satisfying object for such projection. Thus, those who readily accept the need for careful protection of legal rights, from arrest to the court hearing, are easily tempted to overlook such elements when it comes time to decide what is best done in the interests of the child. By limiting the disposition powers of the court, *Standards* offers a continuing protection that can stand in the way of such projection.

On the other hand, social workers, professionally disciplined with respect to the use of themselves in the helping task, are accustomed to thinking of this discipline as a guarantee of the protection of the client. This is not necessarily equated, however, with liberty in its political or legal sense.[3] Nevertheless, in their concern with the needs of the child or his family, social workers become impatient with legal safeguards, such as rules of evidence, evolved from hundreds of years of legal experience and history and which still represent the most universal and applicable form of protection yet devised.

There is no reason, however, why the social worker, accustomed to working within the limitations and regulations of the social agency, cannot accept the legal limitations which constitute the framework of the court. That the task will be easier if *Standards* is followed, cannot be denied, for the court's legal structure and procedures would then be addressed, like the social agency's own policies, toward the fulfillment and achievement of service. Social work's quarrel, if it can be termed that, with due process of law as exemplified in some courts, is not in reality a resistance to the protection of the individual's rights. It is simply in protest against those legal limitations or procedures which bear no dynamic relation to the individual as such. Conversely, those in the court representing the field of law are not really in opposition to a limited and disciplined helping process as an integral part of the court's procedures. Their opposition is only to that kind of helping which ignores the special obligations of the law. If each could see the special nature of the other's discipline, while holding fast to a broader application of his own, encompassing *Standards* as a whole would be an easier task.

Over the past 25 years there has been sharp conflict between those who would see the court as primarily a social agency and those who would limit the juvenile court to a judicial determination of facts with treatment decisions placed in the hands of an administrative agency. The former would minimize the legal or judicial components of the court, while the latter would hold the court's powers to a mere judicial determination of the facts at issue.

Standards presents a firm ground for resolving this tiresome controversy. The point of view held by *Standards* confines the court's functions to conducting hearings and making dispositions in every instance in which the right of a parent or a child may be curtailed by authoritative action. It is with the details of arrests, investigations, hearings, adjudications, and making of dispositions with which *Standards* is largely concerned. It is here where the special genius of the work has merged law and social services into an orderly, purposeful, disciplined helping process demanding the best of each profession. It is here that mutual respect and a willingness to work together must be forged. *Standards* points the way for this working together in order that the real effectiveness of the specialized court dealing with children may be revealed to the advantage of all.

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[1] Juvenile-court standards: report of the committee appointed by the Children's Bureau, August 1921, to formulate juvenile-court standards. Children's Bureau Pub. 121. Washington, D. C.: Government Printing Office, 1923. 10 pp. (out of print).

[2] Standards for specialized courts dealing with children. Children's Bureau Pub. 346. Washington, D. C.: Government Printing Office. 1954. 99 pp. 35 cents.

[3] Keith-Lucas, Alan: The political theory implicit in social casework theory. *The American Political Science Review* 47: 1076–91. Dec. 1953.

A NEW LIFE SAVING SERVICE FOR CHILDREN IS LAUNCHED

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A POISONING CONTROL PROGRAM, the first of its kind in the United States, is under way in Chicago. Developed by the Illinois Chapter of the American Academy of Pediatrics and approved by the Chicago Medical Society, this program is designed primarily to aid physicians in treating children who have accidentally swallowed household substances that may be poisonous and to prevent future poisoning cases. Already, similar programs are being considered in a number of other cities.

A Serious Health Hazard

The National Safety Council has estimated that there are 187,500 cases annually of accidental poisoning in the home, and that 1,250 of these result in death. This is of particular interest to pediatricians because the individuals most affected are infants and children who swallow cleaning fluids, fuel oil, insecticides, drugs and other substances found around the kitchen, the basement, the garage, and the yard. This is a hazard that is increasing rather than decreasing. The scientific and technological advances that bring new vaccines and antibiotics to conquer disease also bring new synthetic insecticides, weed killers, rat poisons, detergents, home permanent wave solutions, and other dangerous substances in reach of almost every infant and child.

In this country about 400 children under 5 years of age are known to die each year from accidental poisoning in the home. This represents a death rate 4 times as high as the British rate for this cause and this age group. Death rates in the United States and in Great Britain are generally comparable and such a large difference for one specific rate calls for careful examination. For this reason the deaths from accidental poisoning of children under 5 years of age that occurred during 1949 and 1950 have been analyzed in considerable detail.

A report on this subject[1] by Dr. Katherine Bain of the United States Children's Bureau shows that foodstuffs are no longer a common source of poisoning. Only 8 deaths due to this cause occurred in the 2 years under investigation, and these were attributed to such substances as wild berries, toad stools, and green pecans. Slightly less than a third of the deaths were due to drugs or medications. A little more than a third were due to general household items such as bleaching agents, furniture polish, and moth balls. A quarter were due to petroleum products, principally kerosene. Five percent of the deaths due to poisoning in the home were unclassifiable because of insufficient data on the death certificates.

Some of the drug poisoning in small children is due to over dosing, but a great deal of it is like any other household poisoning—the child simply swallows something he has found. The most common drug killer in this age group is aspirin. The next most frequently lethal drugs are the barbiturates.

The American people spend a great deal of money on medicines. In 1951 the public spent about three-fourths of a billion dollars on prescriptions and a full billion dollars on packaged medication, of which $135 million went for aspirin and analgesics.[2] This means that practically every household has some type of pill or medicine around. Too frequently adults assume that these drugs are harmless and leave them where young children can easily reach them.

Kerosene, especially among rural and low income families, is another health hazard. Each year there are more than 100 deaths from this cause among children under 5 years of age. This is one of the major factors in the high United States rate compared with the British. In the United States the nonwhite rate for this cause is about 6 times the white rate.

Even when kerosene is considered as a separate

class the largest number of deaths occur in the category of general household items. Caustic substances, such as lye and ammonia, cause an appreciable number of deaths each year; rat poisons and fly sprays continue to be hazards to young life, and some of the newer insecticides and pesticides are appearing in the list, such as DDT, parathion, and its very toxic derivatives. But the list also includes a great variety of items, such as permanent wave solution, shampoo, lighter fluid, rubbing solution, bleaching agent, antifreeze, moth balls, furniture polish, and other common household substances.

The fact that 5 percent of deaths from poisoning cannot be classified because of insufficient data on the death certificates shows that physicians as well as parents need education in this problem. An autopsy should always be obtained on an obscure case since an accurate diagnosis is necessary if similar accidents are to be prevented.

Childhood deaths from poisoning occur disproportionately often in 12 Southern States—Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia. The rate for these States as a group is 4.09 per 100,000 population as against 2.00 for the remainder of the country. For the barbiturates and aspirin there is little regional difference. But for corrosives and arsenic the rate for these southern States is 6 times that for the rest of the country, and the rate for petroleum products (principally kerosene) is 4 times as high there as elsewhere. Lead poisoning is more common outside the South. This may reflect a regional difference in the use of paint, or it may reffect the better diagnostic facilities in urban centers.

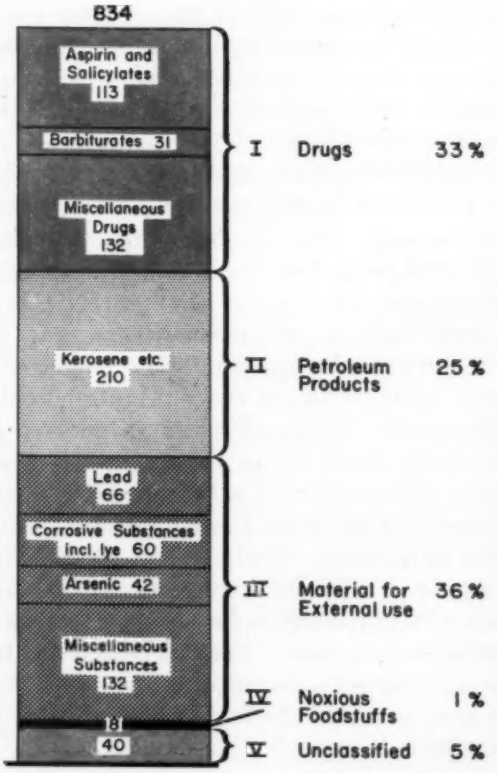
Treatment Problems

Relatively little is known about poisons and the specific treatment of poisons, although the average home is loaded with potentially dangerous items. It is impossible for the practicing physician to keep posted on the identity of the toxic constituents involved in the large number of household items that are poisoning hazards. And even when the substance has been identified, there may be differences of opinion as to what is the best treatment.

When a child has swallowed some household substance, the label on the package may not tell the physician what he needs to know. The Federal Food, Drug, and Cosmetic Act makes specific requirements with regard to the appropriate labeling of each of these kinds of substance. For example, drugs, to be properly labeled, must bear adequate directions for use and warnings or precautions against misuse. The Caustic Poison Act requires that 12 designated caustics and corrosives when present in specific amounts in consumer-sized packages shall be labeled with the identity of the substance, the word "poison," and directions for emergency treatment, including an antidote statement, in case of misuse. But this leaves a wide area of household materials untouched. There are many hazardous chemicals to which the householder is exposed which are not covered by labeling laws. For example, silver polish may contain cyanide, or a cleaning fluid, carbon tetrachloride.

The number of potential poisons and the related facilities for clinical and chemical analysis are so complicated and extensive that it is not feasible even for a large hospital to have its own comprehensive toxicological laboratory. Moreover, there are very few poisonous substances for which an analysis can be made rapidly enough to be of help in immediate treatment. In most instances it requires at least 3 to 4 hours to get results of the analysis. Certain

SUBSTANCES RESPONSIBLE FOR DEATH FROM ACCIDENTAL POISONING OF CHILDREN UNDER 5 YEARS: U.S. 1949–50



types of analyses, such as that for lead poisoning, require special facilities that are not available in most cities.

Even when the specific poison is known, there is much to be learned about the most effective methods of treatment. For instance, there is a difference of opinion among competent physicians as to whether or not gastric lavage is advisable for such common toxic substances as lye or kerosene. Many physicians believe that lavage should not be used when either of these 2 substances has actually been swallowed. Others, including the author, feel that if done carefully, with a well lubricated tube, within 30 to 60 minutes after ingestion, lavage may be life saving.

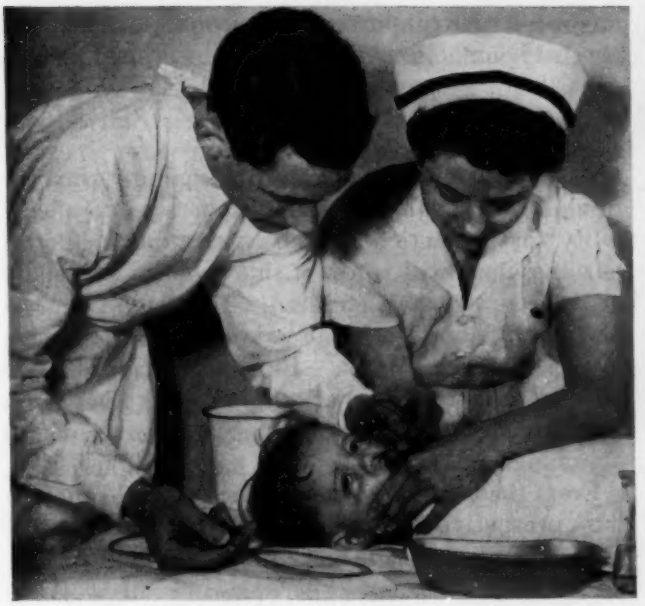
There is an acute need for a central clearing house of information on poisons, that can be immediately available to physicians and hospital emergency rooms. But an entirely comprehensive list of poisons would be an extensive job and require a great deal of time and money, and would have to be a nationwide service.

The Chicago Trial Program

Before attempting to set up such a program on a permanent or citywide basis, the Committee on the Chicago Center for the Control of Accidental Poisoning in Children, of the Illinois Academy of Pediatrics, conducted a trial program which lasted 3½ months and covered 6 hospitals. In this undertaking, the Committee had the backing of Chicago's five medical schools, the city Board of Health, and the State Toxicological Laboratory.

Participating hospitals reported all cases of accidental poisoning in children treated in their emergency rooms to the Chicago Board of Health. A uniform reporting form was developed by the Committee for this purpose. Reports were analyzed and summarized by the Board of Health, with the guidance of the Committee members. The summaries showed the total number and types of cases treated, the number of deaths, and the comparative effectiveness of various treatment procedures. Analyses were made to reveal any significant increase or decrease in the incidence of poisoning or its virulence.

A manual summarizing the latest methods for treating various types of poisoning, together with cross references to published lists on the contents of thousands of household substances, was developed and is being kept current by additions and revisions. This and other information which is not in form for general distribution was made available to the participating hospitals.



Before Chicago's poisoning control program was even tested, it had behind it the support of the city's five medical schools, the State Toxicological Laboratory, and the City Board of Health, as well as the counsel of such national groups as the American Medical Association, the National Safety Council, and the Federal Food and Drug Administration. This small patient is having his stomach emptied by a resident physician on the staff of the Children's Memorial Hospital, one of the six test hospitals.

One hundred and fifty-five children were treated in the 6 cooperating hospitals during the trial period. These children had swallowed a variety of substances, including rat poison, turpentine, kerosene, insecticides, liniment, bleaches, and lye.

None of these cases proved fatal. This fact is not statistically significant since there is no adequate basis for comparison. But the services were felt to be beneficial and recommendations were made to put the program on a regular operating basis and to make it available to other hospitals and physicians.

In the Chicago program, there were 20 cases of poisoning by fuel oils. This is not as large a proportion of the poisoning cases as the national mortality rates would lead one to expect, but it is a higher proportion than in the rate for the United States exclusive of the 12 southern States. The remaining cases were equally divided between medications and general housekeeping materials. But in this grouping liniment, for example, is included under medications. If materials intended for external use had been classified under household items, as in the national survey, the Chicago experiment would show

an even larger proportion of poisoning cases due to general household items than do the national figures.

Prevention Is Important

A facility for the control of poisoning, primarily in children, should necessarily take some responsibility for prevention as well as treatment. Better labeling alone will not meet this problem, especially in the case of small children. The public, and in particular parents, need special instruction in regard to poisoning prevention. Before this can be done efficiently, more information must be gathered on the circumstances surrounding each accidental poisoning.

From the beginning of the Chicago trial program this preventive feature was stressed. Board of Health personnel made home visits and other followup contact measures, wherever indicated. Altogether, 55 home visits and 32 telephone followups were made. Thirty-eight of the home visits and 15 of the telephone calls led to corrective measures likely to prevent similar accidents from recurring.

In one case, for example, a boy under 2 years of age was being cared for in his parents' absence by a pregnant aunt who lived in the upstairs apartment of the patient's building. The sole source of heat in this apartment was an old kerosene stove which leaked. The drippings were caught in an ordinary drinking glass placed on the floor. While the aunt's back was momentarily turned the child who was playing on the floor drank some of the kerosene.

Immediately the boy began to cough violently and vomited a little. The parents had no family physician. They brought the child directly to the emergency room of the County Hospital. Here his stomach was emptied and washed with tap water within a half hour of the time he had swallowed the kerosene. The boy seemed all right, but because of prior experience with kerosene poisoning the hospital authorities decided that he should be hospitalized and treated with penicillin, streptomycin, and steam inhalations. In spite of this he developed early signs of pneumonia. Oxygen was added to his treatment regime. Within 4 days he was well enough to be discharged and followed later in the clinic.

When this case was reported to the Chicago Board of Health, a nurse made a followup visit to the home. The stove was still leaking kerosene and there was broken glass on the floor. Furniture polish, shoe polish, bleach, and other household items were stored in a box on the floor of the living room. The family was strongly urged to place these items on shelves out of reach of the child, and to have the stove repaired. In a later telephone check it was learned that the recommended precautions had been taken.

In another case, a 15-month-old child had swallowed a cresolic disinfectant. He was successfully treated but at the home followup he was found chewing paint from the window sill. The danger in this practice was explained to the mother and steps were taken to prevent further paint chewing.

Spreading the Idea

Both the American Academy of Pediatrics and the American Medical Association have been interested in the problem of accidental poisoning for several years. The Academy of Pediatrics through its Accident Prevention Committee, with Dr. George Wheatley as Chairman, has encouraged pediatricians to include accident prevention activities of all types in their daily medical practice. The encouragement and stimulation of this committee was one of the major factors in helping get the Chicago program started. Moreover, they are taking an active role in helping implement the interest and plans for similar projects of physicians and local chapters in Boston, Cincinnati, New York, Washington, D. C., and other cities. It is felt that the central office of the

As important an ingredient in Chicago's poisoning control program as treatment is the preventive work done by the city Board of Health which sends workers into homes to advise parents on safety measures. While this mother's back is turned, a visiting public health nurse stops the small daughter in the act of reaching for a can of drain cleaner which is a lye compound. Parents are made alert to many apparent trifles which can, and do, bring tragic consequences.

Academy of Pediatrics in Evanston, Ill., may well serve as a clearing point for various local poisoning control centers throughout this country as well as other countries that are members of the American Academy. This would help promote a more thorough and widespread dissemination of information on the subject.

The Council on Pharmacy and Chemistry of the American Medical Association through their Committee on Pesticides has been interested in the problem of poisoning from insecticides, rodenticides, herbicides and related materials for several years. The secretary of this committee is also a member of the Chicago Poisoning Control Program. As a result of the general interest in the subject of poisoning on the part of the American Medical Association, the American Academy of Pediatrics, and others, and encouraged by the Chicago Program, the American Medical Association has under consideration the formation of an overall committee on toxicology. Such a committee could gather information on toxic reactions to new drugs, or new toxic reactions to older drugs and proprietary remedies, as well as on new household products, pesticides, and related substances. It could receive and collate reports on poisoning in children funneled through Academy of Pediatrics channels. In addition it could get reports on other toxic materials sent in by physicians in industry and related nonpediatric fields.

In the long run, poisoning prevention depends on knowledge. We must have the information as to what is contained in various household substances. We must also have the information that can only come from home visits or other careful followup as to the various practices and living conditions that put these substances within the reach of children. And we must pass this information on to the public. A poisoning control center should attempt to get this public health information into the home at the same time that it is providing physicians and hospital emergency rooms with more technical knowledge regarding analysis and treatment.

[1] Bain, Katherine, M. D.: Death due to accidental poisoning in young children, to appear in *Journal of Pediatrics* June 1954.

[2] Olsen, P. C.: Three year report on 222 drug store product lines. *Drug Topics* 96: 1, Aug. 11, 1952.

INDUSTRIES HELP IN SAFEGUARDING CHILDREN

Accidents kill and cripple more children in the United States of America than all the infectious diseases of childhood put together. Motor vehicles are the greatest single cause among children over 1 year of age. For infants and preschool children, accident risks are greatest in the home.

Increasingly, preventive measures are challenging the ingenuity of many groups working with children, stimulated greatly by the American Academy of Pediatrics' Committee on Accident Prevention. Industries are joining forces with public health and other authorities to put their customers on guard against possible dangers, and to aid health workers reduce the toll of child life.

The Chemical Manufacturing Association and the Chemical Specialties Manufacturing Association have worked with the New York State and City health departments on a new chapter to that State's Sanitary Code. This will call for more informative labeling of containers of hazardous substances, both to motivate parents to keep toxic household substances out of reach of children, and to inform physicians of ingredients that may have been ingested.

Burns, explosions, and fires are a frequent cause of home-accident deaths among young children, especially those in rural areas. The American Petroleum Institute has made a film explaining, in simple ways, the explosive properties of home and tractor fuel and power oils. Copies of this film are made available, on free loan, to agriculture educational centers.

What seemed, in the late summer, 1953, to be an epidemic of child deaths due to suffocation in discarded refrigerators has moved the Refrigeration Trade Association of America to step up its educational efforts of prevention. This Association has been working with local groups in drawing up codes covering the disposal or care of unused iceboxes. Too, it has been urging its 8,000 members to include, as part of their normal service in installing any refrigerator, an offer to remove doors from replaced units.

The American Gas Association is working on the hazards of gas in domestic use. It has recommended that all gas utility companies adopt and publicize the policy of providing free investigation of all faulty operating gas appliances and free inspection of newly installed gas appliances, with charges only when actual maintenance and repair are required.

Two technical subcommittees of the American Standards Association have been set up recently to study the flammability of children's clothing and the labeling of lead-base paints.

The list of private and public efforts to combat high accident rates among children is long. Cooperating in many of these activities is the Home Accident Prevention Unit of the Division of Sanitation, U. S. Public Health Service, formed 5 years ago. Recently, an informal committee, on which the Children's Bureau has representation, was created by the Unit from among the constituents of the Department of Health, Education, and Welfare. For the immediate future, this committee will focus its attention on all aspects of child safety.

IN THE JOURNALS

Why Babies Cry

An amusing statement that should arouse comment among almost any people who have been privileged to observe babies closely is Saul Rosensweig's "Babies Are Taught to Cry: a hypothesis," in the January 1954 issue of MENTAL HYGIENE. Whether or not readers find his arguments plausible, they will almost without exception give a nod of wry acceptance to his remark that "One must not, however, expect that the baby who has been understood . . . will never cry."

T. and A.? . . . That is the question

Dr. Joseph A. Johnston and Dr. Thomas W. Watkins report in the JOURNAL OF PEDIATRICS for February 1954, on an interesting followup study of 598 cases at Henry Ford Hospital in Detroit in which tonsils and adenoids had been removed. They bring out the importance of a period of observation before a decision to remove is reached, a period long enough to make sure that other causes can be ruled out.

"Stretching the Nurse"

"Never consider any of the duties of your department beneath your dignity as a department head. . . . We are going to have human relations, so they might as well be good." How to go about making relations democratic and profitable between hospital nurses and the aides, volunteers, practical nurses, clerks and others who free nurses for their planning, teaching, and supervising duties is the subject of "Stretching the Nurse," a piece in HOSPITALS for March 1954, by Ruth Sleeper, Director of the School of Nursing and Nursing Service at Massachusetts General Hospital in Boston.

"When will he be 5?"

People whose children's birthdays come at the "wrong" time of year are often irritated over what seem arbitrary rules about school entrance. They and others who have wondered about such questions as the length of the kindergarten day, how many children are desirable per teacher, and whether mothers should stay with their children the first day will be interested in an opinion poll carried on by the Kindergarten Committee of the Association for Childhood Education International, and reported in the March 1954 issue of CHILDHOOD EDUCATION. Neith Headley of the University of Minnesota tells what 180 kindergarten teachers, most of them with 5 or more years of teaching experience, believe. Their intimate acquaintance with young children has led them to the conclusion that it is desirable for a child to be within a month of 5 when he starts to kindergarten; that a 2½- or 3-hour session is more desirable than a 2-hour one; that a teacher handling 25 5-year olds should have an assistant; and that children who have not had nursery school experience should visit the kindergarten with their mothers before it's time for them to enter. Among the other items on which opinions were given are such details as size of kindergarten room, how to report to parents, and readiness tests.

Are their basic rights being denied?

"Home Problems and Family Care of the Mongoloid Child," by Rudolf P. Hormuth, is one of several articles in a symposium on mongolism in the QUARTERLY REVIEW OF PEDIATRICS, November 1953.

Mr. Hormuth, who is Assistant Executive Director of the Association for the Help of Retarded Children, wants professional people to take a sharp look at their practices with regard to mongoloid children. Those who are "most verbal" in the defense of children's rights, he says, "maintain a deadly silence" when these same rights are denied the mongoloid child. Parents are actually encouraged to reject these children, though placement is often so expensive and difficult that the child winds up back in a home and community wretchedly unprepared to accept him.

An objection frequently raised to keeping a mongoloid child at home is the effect on normal brothers and sisters. But Mr. Hormuth's experience is that "very young children show little or no prejudice," and that "if the parents show no prejudice, few of the normal siblings will." When a normal child feels he is being of help to his mongoloid sibling, the author says, "there are no ill effects."

Why do children suck their thumbs?

This perennial puzzler to parents, as well as to pediatricians and psychologists, was studied by Leon J. Yarrow at the Child Research Council in Denver and reported in the March 1954 issue of the JOURNAL OF GENETIC PSYCHOLOGY. Dr. Yarrow tried to isolate some of the factors associated with thumbsucking. One that seemed to be positively related to thumbsucking in late childhood was the amount of opportunity for sucking during feeding in early infancy. The author emphasizes that there are probably a variety of conditions underlying thumbsucking, and not any single cause. The title of the study: "The Relationship Between Nutritive Sucking Experiences in Infancy and Non-nutritive Sucking in Childhood."

What makes people change?

People who try to get other people to accept and put in practice new ideas need to keep in touch with what research has to tell them. In "Changing Family Health Patterns: a review of recent research" (JOURNAL OF HOME ECONOMICS, January 1954), William Griffiths of the University of California cites a variety of studies dealing with health, nutrition, and food habits. The vast importance of considering how people in different cultural settings perceive their needs, and the fact that "many individuals feel most comfortable in carrying over into a new generation the traditional family practices" are effectively illustrated. Evaluation of efforts is imperative, if results are not to be negligible.

A unique population

Joseph W. Eaton and Albert J. Mayer, in HUMAN BIOLOGY for September 1953, discuss "The Social Biology of Very High Fertility among the Hutterites." They show that since coming to this continent about 75 years ago, the Hutterites have set what is probably a world record for population growth, increasing over 4 percent per year or doubling their numbers each 16 years.

Three reasons are found: (*a*) the availability of medical facilities, (*b*) the complete proscription of birth control, and (*c*) the group's religious emphasis on mutual aid. Considered separately, no one of these conditions is unique to the Hutterites, but "what is unique is the combination of the three factors." Personal costs are great, of course, especially to Hutterite women. Despite maternity care, a higher proportion of these women than in other civilized groups fail to live beyond 55 years of age.

This article gives no hint of whether the Hutterites actually have (as claimed in 1951) much less mental illness than their neighbors. The answer to that question is promised in a book due this year.

Telling people is not enough

How to be sure people read and absorb new information intended to be of use to them is the subject of a study on "Pretesting a Pamphlet for Reader Comprehension," by Marie Ford and Ruth Stief, of the Minnesota State Department of Health. Their plan of action involved finding out whether mothers of school children would read a pamphlet their children brought home to them on the nutritional importance of milk and would at the next PTA meeting answer a questionnaire about what they had read. Would their presentation of facts about milk impress people who think it's only for babies and children or that it's fattening?

Even though the material was worked over by means of a simplification of the Flesch reading ease formula some mothers didn't read it. But they contributed their bit, at the meeting, by serving as a control group. In the end, the authors were encouraged to believe it would pay to put *more* information, based on readers' known needs, into readable and attractive—but still accurate—form. The study is reported in the January 1954 issue of the JOURNAL OF THE AMERICAN DIETETIC ASSOCIATION.

Choosing a camp

Alethea T. Beckhard, Director of the Camping Division of the Girl Scouts, and Chairman of the Field Services Committee of the American Camping Association, doesn't believe that there's "a certain age" at which a child should go to camp. But she points out in the Spring 1954 issue of CHILD STUDY, that at one age one camp may be right, at another age a quite different one. "A great display of equipment" may cover up a lack of good program. Variety of activities should be given as careful an inspection as the physical setup. Workers with children will be glad the author stresses the value of family-size groups of 6 or 8, and relieved, perhaps, to know that she favors breadth of interest in the counselors who live with these groups, rather than that each should be bound up in one special hobby.

Community action

In the March 1954 AMERICAN JOURNAL OF PUBLIC HEALTH are gathered together a great many of the words of wisdom spoken at the 81st annual meeting of the APHA. Those who are interested in involving the consumers of public health in its further development, but who did not get to the 1953 meeting will have a sense of having participated when they read 4 papers presented by Dr. Harold M. Erickson, Dr. Richard W. Poston, Dr. Earl Lomon Koos, and Dr. John Porterfield. Dr. Erickson describes two instances of community action in Oregon; Dr. Poston tells how a community can take a look at its total needs and activities, illustrating his points by Montana and Washington experiences. Five ways a community may react to its health needs are pointed out by Dr. Koos, who makes it clear that reaction—positive or negative—depends upon what "health" means to people, how it is valued in comparison with other "symbols of civic pride," and how close people in the community can get together in their thinking.

Dr. Porterfield draws out practical applications from the 3 papers, emphasizing teamwork with the social scientist, and 2-way communication with the people who are both the users of what public health provides, and the payers of the bill. "Public health is not something which can be found in the health department, rather it is in the neighborhoods where people live," as Dr. Poston says.

Blind babies' foremost needs

The natural tendency of parents whose infants suffer from retrolental fibroplasia is to concentrate more on their child's blindness than on his whole-child needs. Because of this it is highly desirable that such sound practical knowledge as Dr. Arnold Gesell gives in THE FIELD OF VISION for December 15, 1953 be interpreted to parents. In "Development of the Infant with Retrolental Fibroplastic Blindness" Dr. Gesell differentiates clearly between these cases and uncomplicated prematurity, in which appraisals of behavior patterns are made in terms of the corrections necessary to indicate the infant's true age.

In the case of the blind premature baby, his total development may be held back if his parents are not early made aware of what a great deal they can and should do during the very first year of life. It is of basic importance, for example, that they stimulate the baby's postural behavior from the beginning.

A wide range of valuable experience is suggested: having a roomy tray for his high chair; many objects for him to play with that he can safely mouth; not letting him lie on his back too much; leaving his legs and arms bare—his sense of touch "embraces the whole skin," says Dr. Gesell. Keep him venturing. "Teaching" him is unnecessary—he will develop if he is plentifully supplied with things and people that encourage him always to reach out, bodily and mentally, beyond himself.

Vandalism can be minimized

A continuous program of constructive citizenship will do the job, say William A. Bristow and Alex H. Lazes of the New York City Board of Education. The authors' claim in THE NATION'S SCHOOLS for April 1954, is bolstered by accounts of what has helped in various cities. They rely on activities that contribute to understanding of what is being attempted, like letting students take part in making school regulations, having them help in decorating the building—their parents, too, sometimes. Sponsoring outdoor school events, providing discussion groups for parents, and involving the student council in planning are other "minimizers."

"The discipline most needed today," the authors suggest, "is that of identification with a group, the assumption of responsibility, and the desire to help find solutions to problems."

A private foundation gives a Department of Health a chance to help a community in . . .

REDESIGNING SCHOOL HEALTH SERVICES

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THE SAN FRANCISCO Community-School Health Education Project, which was in operation from 1947 to 1950, has provided a stimulus toward the development of an integrated health program for school-age children. The project has demonstrated that schools and health departments in metropolitan areas can work together effectively and can develop jointly a more efficient program of services than is possible when each agency works independently.

This project, sponsored jointly by the California State Departments of Education and Public Health, was made possible through a supplementary grant of money which the W. K. Kellogg Foundation made to the State Department of Education for the specific purpose of developing a Community Health Education Project. The responsibility for carrying out the project was shared by the Unified School District, the San Francisco Department of Public Health and the San Francisco State College. The State Department of Public Health assigned a medical officer and a public health nurse to serve in consultant and coordinator capacities.

The results of this study, as they affect education and the classroom teacher, have already been reported.[1] The present report is concerned chiefly with the findings that affect medical and nursing services.

Objectives

The overall purpose of this "Community-School Health Education Project" was to study ways and means by which an effective health education program could be developed with available personnel, time, and budget; and to explore ways by which all persons in and out of school who are interested in, and have a responsibility for, children's health can work together toward improving the health of school-age children.

The San Francisco Project Area

San Francisco, a city of three-quarter million people, has a school population of over 70,000 and more than 2,000 teachers. It was not practical to include all the city schools in this project. The study was limited to an area of San Francisco which represented a cross section of the population and which included an elementary school, a junior high school, and a senior high school, in close proximity.

This provided for continuity of health supervision and health education as the children progressed to the various school levels.

The Central Coordinating Committee

The first step was to organize a Central Committee to provide an administrative framework for bringing problems into focus for discussion, joint planning, and action. The Associate Superintendent of the Unified School District served as chairman for this committee. The membership included administrative staff of the Unified School District; principals from the three selected schools; administrative staff from the Bureaus of Child Hygiene and Public Health Nursing and the Division of Health Education, and the public health physicians and nurses serving the project schools; health education consultants from the San Francisco State College; the medical officer and nurse coordinators lent by the State Department of Public Health; and, during the third year of the project, the chairman of the Health Education Committee of the County Medical Society.

The Central Committee functioned as a planning and deliberative body for policy making. The early meetings were devoted to getting acquainted, learning about the contributions of representative members, and acquiring an understanding of the problems. The reward, after a year of such sharing, was the members' unity of purpose and agreement on objectives and basic philosophy.

The group recognized that while parents have a primary responsibility for their children's health, the community has its responsibility too, and many resources which can contribute; when schools, professional groups and agencies support each other and their services are integrated, the total health program is strengthened.

Approaches to the Problems

One of the first steps was to review and evaluate the current health service activities of school and health department personnel and the existing relationships among staffs working with school children.

In order to accomplish this the physician and nurse coordinators made day-by-day observations of personnel at work; administrative manuals of policies and procedures relating to staff activities were reviewed; conferences were held with administrative and supervisory staff relative to their activities, responsibilities, and relationships, on both the administrative and the staff levels; time studies and job analyses were made; individual pupil health records were reviewed and evaluated; and the forms and methods for interchange of information among staff and between agencies and other professional groups were analyzed.

These studies revealed that the potential contributions of nurses and physicians were not being fully realized because of existing administrative policies and procedures. Coordination of services and channels for interchange of information were neither adequate nor uniform. It was also evident that there was a need to clarify individual and joint responsibilities, as well as to explore better ways of using professional skill and time.

In-service Education

These findings focused attention on the need for a planned intensive in-service education program for all of the staffs concerned in this project. Such a program was organized and geared to meet the needs of the various professional groups, administrators, teachers, nurses, and physicians, respectively and concurrently. Initially these planned in-service education meetings served to orient the entire staff to the changes in concepts, policies, and responsibilities of the individual staff members. As changes in procedures and techniques were developed through the cooperative efforts of the various subcommittees and the Central Committee, the in-service education program provided a means for keeping the entire staff informed so that they could move forward as a team.

A committee of staff members planned an intensive program which included staff meetings and workshops for the nurses and for the physicians, held separately and jointly. Throughout the period of the in-service education program, there was a continuing review of records and evaluation of the program—in terms of progress, areas which needed strengthening, and next steps. This democratic approach encouraged participation of the "grass roots" staff in these meetings, awakened initiative which has been dormant, and did much to stimulate and encourage the team concept.

Other workshops provided for joint participation of staff of the Health Department and the administrative personnel of the Unified School District. These were arranged for the purpose of interagency orientation in regard to the services and contributions each of these agencies provided for school-age children, and exploration of ways by which these services could be better integrated.

Special resource consultants from within San Francisco and the surrounding area were made available periodically for combined (public health, school, and State College) staff workshops on special aspects of the project, including evaluation and problems of working together.

Changes in Policy

One of the first changes in policy governing health services was the elimination of routine examinations in specific grades. Instead, children in need of service because of suspected health problems observed by the teacher or nurse, or sometimes the parent, were given first priority. This released more physician time for careful history and examination of referred children as well as for discussing his findings and recommendations with parents. The role of the school physician was gradually broadened to include health guidance and health education for school staff as well as parents, in relation to individual and group health problems.

Another change in policy was directed to better utilization and integration of private physicians' services. This eliminated much of the waste resulting from duplication of school physician and private physician services.

School Health Service Records

The limitations of space on the medical and nursing school record in use before the project was started required that a code be used to indicate health defects. In addition to being difficult to interpret, the code was inadequate for conveying information needed by the nurse or teacher in followup. Changes in policy permitted the cooperative development of an entirely new medical and nursing record in which the code was eliminated and adequate space provided for recording meaningful pertinent information regarding the child's health problem, the medical findings, and followup recommendations for the parent, the nurse, or the teacher.

At the same time that the new medical and nursing record was set up, a permanent form (Teacher Observation of Pupil's Health Record) was introduced for recording health deviations observed by the teacher and for recording information shared between the teacher and the nurse or physician, or other combination of school staff. Such sharing gave the teacher a better understanding of the child's health problem and her role in the followup recommendations made by either the school physician or the child's private physician. Furthermore, since this record was kept in the classroom and followed the child throughout his school period, each new teacher, at the beginning of each school term, acquired valuable information on each child's health status and her part in the followup.

As the project progressed and the concept of teamwork became better understood and appreciated, the 15 to 20 minutes allowed for medical examinations of referred children proved to be inadequate for obtaining the detailed history which the school physicians felt they needed if they were to understand the impacts in and around the home that had a bearing on the child's health problem.

A subcommittee comprising physicians, nurses, principals, and teachers was appointed to devise a health history form to be filled out by parents which would meet this need. After much deliberation, a form was developed which included information needed by, and of value to, all of the different members of the school staffs. The new form also made it possible to discontinue use of the many separate forms sent by the school to the parents from time to time requesting bits of specific information. This complete health history form, called the "Health Inventory" was submitted to the Central Committee for approval.

Although members of the Central Committee and others expressed skepticism regarding the willingness of parents to cooperate in filling out the form, they agreed to use it on a trial sampling in the project elementary school. The sample represented about 60 percent of this school's population, and included the kindergarten, first, third, and sixth grades, and participation of over 50 percent of the teacher faculty. A carefully worded letter addressed to parents, interpreting the Health Inventory, was jointly prepared by the staff and signed by the principal. This letter, attached to the Health Inventory, was distributed by the teachers to their pupils to take home for the parent to fill out and return to the school. Within 10 days 89 percent were returned completely filled out; in 3 weeks the percentage rose to 93.

Through the Health Inventory, a fund of very valuable information was secured from the parents on family background, current health practices, the parents' evaluation of the child's physical and emotional health status, and the amount of medical and dental supervision which the child was receiving. Such data, for the first time, were now available and readily accessible to the school staff. This informa-

tion provided an excellent device for screening children with health problems and revealed many clues which were helpful in bringing unsuspected health problems to light. Whenever the teacher referred a child to the physician or nurse she always sent the child's "Teacher Observation of Pupil's Health Record" to which the child's Health Inventory was attached. Thus the parent's and the teacher's evaluations provided the health service staff a broader base upon which to make recommendations.

Medical Advisory Committee

Tabulation and analysis of the data recorded on the Health Inventory revealed that during the previous 18 months 77 percent of the children had been seen by private physicians. This pointed up the need to direct efforts toward securing greater private-physician participation in the program. To achieve this end, a representative group of private physicians was invited to serve on an advisory committee.

The active cooperation and participation of the advisory committee brought about better understanding on the part of the medical profession of (1) the current school health program and its objectives, (2) the legal and other responsibilities of schools for pupil's health, (3) the Health and School Departments' roles in the School Health Program, (4) the health problems prevalent among school children, and, most important of all, (5) the private physicians' contribution to the Community-School Health Program. Through joint effort, a form was developed to provide a better channel for the flow of information from the school staff to private physicians and from private physicians to the schools. In addition, the members of this medical advisory committee projected future plans which would provide for orientation of the members of the County Medical Society to the Community-School Health Program.

Integration of Other Community Agencies

By January 1950, the group workers in the official and voluntary recreation agencies were brought into the team. During the remaining 6 months of the project, these group workers, together with personnel in the project, explored ways and means of exchanging health information on the children for whom these agencies were providing services.

Summary

A demonstration Community-School Health Education Project, sponsored by the State Departments of Education and Public Health, was carried out by the San Francisco Unified School District, Department of Public Health, and State College with supplementary funds provided by the W. K. Kellogg Foundation.

A central coordinating committee with representation from School and Health Departments, State College, and County Medical Society provided the administrative framework for bringing problems into focus for discussion, joint planning, and action. As the members were able to establish empathic relationships with each other and greater understanding developed, unity of purpose, and agreement on objectives and basic philosophy were achieved.

The review and evaluation of the activities of school personnel, the relationships among staff providing services to school-age children, and the adequacy of records and other tools used in the program, was an effective means of bringing problems to light and directing joint efforts toward their solution.

Among other things, the united team approach succeeded in: (1) clarifying joint and individual responsibilities; (2) developing new records and tools for sharing and channeling information about children's health between school staffs and between the private physicians and schools; (3) making more effective and economical use of professional time and skills; (4) directing medical services to children in need and eliminating duplication by integrating private physicians' services in the total program; (5) securing the interest, cooperation and active participation of parents, physicians, and community agencies serving children; and (6) carrying out an intensive inservice education program geared to the needs of staffs serving school children.

The project demonstrated that school people and health department people can work together for a really good, effective school health program, if they have a strong desire to do so and take time to understand each other. This combined effort is not only sound, but it is economical; no more people have to be hired, no more money is required, there is no costly duplication of effort, and all the resources are used to advantage.

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[1] Mealy, Ethel, and Corbett, Alice M.: What shall I do? The classroom teacher's role in the health education program for elementary school children. *Journal of the American Association for Health, Physical Education and Recreation* 21: 28, October 1950.

Conlon, Louis G.: The organization and administration of an improved health education program for eight senior high schools in San Francisco Unified School District. Doctorate Thesis, University of California, Berkeley, Calif.

PROGRAM DEVELOPMENTS

In big and little ways, the people of the Nation keep building better ways of life and greater chances for a wholesome, satisfying childhood for its youngest citizens. Here are some notes on problems and gains gathered from reports by the Children's Bureau staff.

Hints were given at the annual meeting of the American Academy of Pediatrics in Florida in October 1953, that research relating to the cause of retrolental fibroplasia (a type of blindness occurring almost inclusively in prematurely-born babies) is producing results. . . . The Academy passed a recommendation for the fluoridation of water and a resolution backing the program of vaccination sponsored by the National Foundation for Infantile Paralysis.

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In 7 years—from 1946 to 1953—the number of rural counties with the services of a full-time public child welfare worker increased 41 percent. By June 30, 1953, 48 percent of the 2,489 rural counties of the country had such services. This compares with 68 percent of the 698 urban counties, but the increase in these counties from 1946 amounted to only 17 percent.

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Five hundred workers in 47 State public child welfare agencies concluded a period of educational leave during the year ending August 31, 1952. This represented 10 in every 100 persons employed full time in the public child welfare services program. Six out of 10 took their first year of professional training; the other 4 completed their second year. Although these workers had studied at 49 different schools of social work, more than half were concentrated in 8 of these schools.

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Recent studies of handicapping conditions in childhood provide a basis for at least *tentative* estimates of their prevalence in the United States. These indicate some 675,000 children under 21 years of age have rheumatic fever or suffer from its after effects. Cerebral palsy affects about 285,000 children, and epilepsy a nearly equal number in this age group. Nearly 5,000 infants a year are born with cleft palate or lip. In 1952 there were about 64,000 children under 18 with this malformation. Children in need of eye care numbered that year some 7½ million. Hearing loss sufficiently great to warrant further study affected about 5 percent of school children. Some 2 million children, or 5 percent of those 5 to 20 years of age, have speech disorders of such severity as to interfere with educational progress and social and emotional development.

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The four leading crippling conditions diagnosed in State crippled children's programs in 1950, according to a recent analysis made by the Children's Bureau were: congenital malformations, diseases of the bones and organs of movement, poliomyelitis, and cerebral palsy.

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Federal child welfare services funds in 1952 accounted for $1 in every $5 spent for professional services and administration (excluding payments for foster care) in public child welfare programs. The Federal share was larger in rural and low-income States than in urban, high-income States. Expenditures per child under 21, contrariwise, were larger in the high-income, than in the low-income, States. Of total public child welfare expenditures, nearly 73 percent was for foster-care payments. State and local funds were used for most of this cost.

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Teen-age efforts to do something constructive about the problems which careless or "show-off" teen-age driving create are taking several directions. A permanent Teen-Age Traffic Safety Association has been set up in **Colorado** through which teen-age clubs in the State's schools will be formed with the dual purpose of increasing awareness of traffic problems and of working to solve them as they develop locally. **Florida** has a Youth Safety Council which hopes to establish a counterpart in every high school in the State. Statewide driving clubs have been organized in several States.

An agreement to assume responsibility for maintaining a flow of information to the National Advisory Council for State and Local Action on Children and Youth was signed in October 1953 by the Interdepartmental Committee on Children and Youth, whose membership includes representatives from 9 major Federal agencies embracing 29 bureaus and offices.

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The Chief of the Children's Bureau, United States member of UNICEF's Executive Board, was reappointed in October 1953 to the Joint Health Policy Committee of UNICEF and the WHO.

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A county health department "costs about as much a year per person as a dozen eggs." A county health department "will cooperate with but not replace private physicians and voluntary health agencies." Statements such as these helped to convince the residents of **Bucks County, Pa.**, that they should vote "Yes" last November when a public referendum on the issue was held. Their 2 to 1 support of a county health department made Bucks the first county in the State to approve such a program by referendum.

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From 6 States reports have recently come of progress in public-voluntary agency teamwork in meeting the needs of childen:

North Dakota is using a committee made up of representatives of the State Division of Child Welfare and voluntary agencies to develop standards for child-caring institutions.

Pennsylvania has a similar committee to evolve standards of operation for its new adoption law.

The Catholic Charities in El Paso, **Texas**, has asked for help from the State Division of Child Welfare and the Children's Bureau Consultant on Group Care on reorganization plans for Catholic institutions.

The **District of Columbia** has a citizens' committee gathering information about child dependency and using, in the process, staff from both public and voluntary agencies as resource persons.

Administrators of protective services in Fresno, **California**, are working with other agencies and citizens' groups in an interesting way. An inter-agency screening committee has been established to which all situations of neglect

are referred. After reviewing each case, the committee recommends what referral should be made: to Protective Services, to an agency already known to the family, or to a law enforcement agency for removal of the child. Citizens' groups, such as church and service clubs, are brought in to assist in securing material things needed by the family that cannot be supplied through the child welfare activities. By this device, citizens in general are helped to understand the ways in which services work with families and children.

Colorado's Division of Child Welfare has given its State Child Welfare Advisory Committee responsibility for developing closer working relationships between public and voluntary agencies throughout the State. Under this plan, a member of the Committee took leadership in planning and chaired an institute in Pueblo on services to children in their own homes, which was addressed by the State's consultant on these services and to which workers in public and private agencies in the community came. Advisory Committee members are taking leadership in other gatherings similarly designed to promote better services to children.

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To reach unmarried mothers who might not otherwise know of the help available to them, the **Texas** Department of Public Welfare, in cooperation with public and private licensed child placement agencies and licensed maternity homes in the State, has just issued a pamphlet, "Helping the Unmarried Mother and Her Child." Listing the agencies and the kinds of services given unmarried mothers, the pamphlet is being widely distributed throughout the State.

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A program of nursery schools for hard-of-hearing preschool children has been set up by the **Massachusetts** Department of Public Health. Seven such schools, located in public libraries, public schools, and Visiting Nurse Association headquarters, have been established to help in preparing these children for regular school classes. Centers have electronic auditory training aids. Some of the children get instruction in operating and using some auditory trainer aids that can be taken home. Lip reading and speech training teachers in the public school systems staff the nursery centers, and parents help in carrying out some of the educational therapy.

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Developments in programs for children in the **Virgin Islands** since the Mid-century White House Conference on Children and Youth are outlined in a report, "What Bends the Twig," prepared by the Insular Advisory Commission on Children and Youth.

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Impressed by the interrelationship of maternal care and mental health effectively set forth in Dr. John Bowlby's monograph on the subject for the World Health Organization, the Greater New York Fund is making special grants, totaling $400,000 over a 3-year period, to 8 pilot projects designed to prevent family breakdown and the uprooting of children. While none of the projects is claimed to be new in concept, the Fund believes "in their present application, they are new to this community."

Recipients of the grants are expected to develop:

"(1) continuous and long-term homemaker and casework service to keep children in their own homes when the family in broken by illness or death but the physical structure of the home remains intact and a responsible parent or relative is willing and able to carry on with this help and support;

"(2) cooperative action between 2 agencies where a family is requesting placement of children but there is reason to believe that placement is neither necessary nor desirable and the home can be reestablished with the aid of intensive casework services; and

"(3) psychiatric treatment for disturbed children in their homes to avoid costly and often unsatisfactory placement or hospitalization."

At least 3 reports annually will be made to the Fund by the grantees which undertake also to make every effort, if warranted, to continue the projects after the special grants cease.

Agencies receiving the grants are: Brooklyn Bureau of Social Service and Children's Aid Society; Catholic Charities, Archdiocese of New York; Catholic Charities, Diocese of Brooklyn; Community Service Society; Federation of Jewish Philanthropies of New York; and the Council Child Development Center.

Home Help and the Nations, just received from England, reveals the widespread and growing importance of a service that is kin to the burgeoning Homemaker Service in this country, which, in some communities, is doing an invaluable job of helping to hold families together when mothers are ill or hospitalized. A report of the "First International Conference on the Home Help Service," held in London in May 1952, gives developments in Belgium, Holland, Great Britain, Sweden, Norway, Finland, Germany, Switzerland, France, Austria, and the United States, where public or private agencies undertake to provide trained and supervised "home helps" or their equivalent to families with special or serious chronic conditions. "The impression gained during 3 days' intensive study," says the report, "was that the home help service is one which is sympathetically regarded throughout the world." So profitable was the exchange of information between representatives of these agencies that arrangements are being developed for a second International Conference to be held in Paris in the near future, and for the formation of an International Council.

SWEDEN'S "home helps," characteristically are civil servants, employed by municipalities to take over the duties of a sick or overworked housewife. More than a houseworker, a "home help" looks after the children, their schoolwork, and their play. To qualify for this work, she is given 15 months of training.

Copies of the pamphlet may be obtained for 12 shillings 6 pence, from the sponsors of the 1952 gathering, the National Association of the Home Help Organizers, 53 Jedburgh Street, Battersea, London, S. W. 11, England.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

ALL MY BABIES. 60 minutes, sound, black and white, purchase or rent.

A real midwife in a meager rural setting is the heroine of this story of prenatal care and birth, filmed for use in the training of midwives in Georgia. The tenderness and insight with which the midwife helps the family constitute a humbling and touching lesson in the essentials of good "human relations," whether learned in a college course or gained through compassionate human experience. The film is "designed to improve existing services to mothers and children but not necessarily to approve or promote the particular type of care represented."

Audience: Professional personnel only. Restricted to official health agencies, accredited hospitals, medical societies affiliated with the American Medical Association, accredited nursing associations, and government agencies with programs of health education in foreign countries.

Produced by: Medical Audio-Visual Institute of the Association of American Medical Colleges under the auspices of Georgia Department of Public Health.

Distributed by: Columbia University Press, Center for Mass Communication, 1125 Amsterdam Avenue, New York 25, N. Y.

FAREWELL TO CHILDHOOD. 23 minutes, sound, black and white. (Emotions of Everyday Living Series), purchase or rent.

Both sympathy and humor characterize this portrayal of the distress of the parents of a 16-year-old who, in trying to grow up, seems to be bypassing them. Though these parents get some relief through the good offices of the counselor whom their daughter admires and confides in, there is pointed recognition in the film of the fact that there will be a succession of other familiar problems typical of adolescence.

Audience: Parents, teachers, adolescents. Should be shown only with a competent discussion leader in charge.

Produced by: Herbert Kerkow Productions for North Carolina Board of Health, under sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; the following regional film libraries for rent—American Film Registry, 24 East 8th Street, Chicago, Ill.; Bailey Films, Inc., 6509 De Longpre Avenue, Hollywood 28, Calif.; Contemporary Films, Inc., 13 East 37th Street, New York, N. Y.; Visual Education Service, 116 Newbury Street, Boston 16, Mass.; Instructional Materials Center, Colorado State College of Education, Greeley, Colo.

FEARS OF CHILDREN. 30 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent.

The frankness and sympathy of a neighbor who has been through similar problems help the parents of a 5-year-old boy to gain understanding and insight. The mother, by babying the little boy, and his father, by leaning in the opposite direction, have encouraged and reinforced their child's fears. The good features of their relations with their son are also shown, so that a realistic picture of family life, not a depressingly blameful one, results.

Audience: Parents, teachers, nurses, social workers, and all others who are interested in how children react to the personalities and practices of their parents.

Produced by: Julien Bryan International Film Foundation for Oklahoma Department of Mental Health, under sponsorship of Mental Health Film Board.

Distributed by: (Same as Farewell to Childhood)

THE HANDICAPPED GO CAMPING. 10 minutes, sound, color, loan.

That camp life is possible for children with varying degrees of physical handicap is clearly demonstrated by this picture of life in a camp for both normal and handicapped children. Enough detail is shown so that the special problems of such a camp, such as the need of an unusually high proportion of counselors, are indicated.

Audience: Camp directors and adults concerned with the needs of handicapped children.

Produced by: Agricultural Extension Service, Washington State College.

Distributed by: Audio-Visual Center, Washington State College, Pullman, Wash.

MEET MAI-DA. 20 minutes, sound, color, loan.

What can be done toward bringing about independence and a normal life in a child born without arms is illustrated by the case of a little Hawaiian girl, Mai-da and her mother spent a year in the United States learning to use prosthetic appliances. The mother's narration of how she handled Mai-da's problems from babyhood on, and Mai-da's obviously cheerful and sunny outlook on life, should give reassurance and new courage to the parents of other handicapped children, no matter what the nature of the handicap.

Audience: Nursing and medical students; also any groups interested in helping handicapped children.

Produced by: Kessler Institute for Rehabilitation, Occupational Therapy Department, Pleasant Valley Way, West Orange, N. J.

Distributed by: Same.

SCHOOL HEALTH IN ACTION. 27 minutes, sound, color, loan.

How a town is aroused to action and the eventual formation of a health council is the theme of this film, itself a cooperative venture of the Oklahoma State Health Department and the State Medical Society. The community is alerted because of the spark set alight in a PTA group by a teacher keenly aware of the need of safety education.

Audience: Community organizations interested in bettering health conditions in schools.

Produced by: Sam Orleans and Associates, Inc., for the Oklahoma State Department of Health.

Distributed by: Oklahoma State Department of Health, Division of Health Education, 3400 North Eastern Avenue, Oklahoma City 5, Okla.

MORE U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

EDUCATION DIRECTORY, 1953–54. U. S. Department of Health, Education, and Welfare, Office of Education. 1954. Part 1, Federal Government and States. 55 pp. 25 cents. Part 2. Counties and Cities. 92 pp. 35 cents. Part 3, Higher Education. 183 pp. 55 cents.

The Education Directory of the Office of Education, issued annually, consists of 4 parts, the first 2 of which have recently come from the press.

Part 1 lists the professional personnel of the Office of Education, the principal State school officers, the executive officers of State library extension agencies, and the principal education officers of the Bureau of Indian Affairs, Department of the Interior.

ACCIDENT FREQUENCY AND PLACE OF OCCURRENCE AND RELATION TO CHRONIC DISEASE; sample of white families canvassed at monthly intervals, Eastern Health District of Baltimore, 1938–43. Selwyn D. Collins, Ph. D.; F. Ruth Phillips; and Dorothy S. Oliver. U. S. Department of Health, Education, and Welfare. Public Health Monograph 14. 1953. 68 pp. 35 cents.

With accidents causing nearly a third of the deaths of children 1 to 14, this study of accidents to persons of all age groups should be of value to many workers interested in saving children's lives. The study found the highest relative frequency of all accidents occurring among children under 15, and the lowest among persons 15 to 34.

Part 2 lists, by States, superintendents of county schools, of supervisory-district or union schools, and of urban schools, by States. It also lists superintendents of Catholic and Lutheran parochial schools.

Part 3, Higher Education, lists institutions offering at least a 2-year program of college-level studies and meeting stated criteria. Among the types of information presented are: names of president and of other officers; accreditation; legal control; enrollment; changes in names of institutions, of classification, or of location; and type of programs offered.

In press is Part 4, Education Associations.

TRAINING AND RESEARCH OPPORTUNITIES UNDER THE NATIONAL MENTAL HEALTH ACT. U. S. Department of Health, Education, and Welfare. Charlotte Green Schwartz. Public Health Service Publication No. 22. Mental Health Series No. 2. Revised January 1954. 16 pp. 10 cents.

A detailed explanation of the Public Health Service program of mental-health traineeships, grants, and fellowships.

A DIRECTORY OF 2,660 16-mm. FILM LIBRARIES. By Seerley Reid and Anita Carpenter. U. S. Department of Health, Education, and Welfare, Office of Education. 1953. 172 pp. 25 cents.

An annotated list of film libraries, compiled for the use of teachers, school administrators, community leaders, and others who use or wish to use motion pictures in their educational and informational programs.

REHABILITATION OF MENTAL HOSPITAL PATIENTS; review of the literature. U. S. Department of Health, Education, and Welfare. Public Health Monograph 17. 70 pp. 1953.

"Within the last 2 decades," says this report, "the orientation of mental hospitals has been significantly changed. The conception of the function of the hospital as a custodial institution for mental patients has been replaced by the conception of the hospital as an institution whose purpose is reeducation and reintegration of the patients into the community."

The report reviews and analyzes current published literature concerning the hospitalized mentally ill—adults and children.

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